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ABSTRACT

This report from a study group on long-term mental illness (LTMI) examines three components of the vocational rehabilitation process (the client, the counselor, and the programs) and the systems through which the three components interact. The first chapter discusses the history and evolution of the vocational rehabilitation (VR) and mental health delivery systems. Other chapters focus on defining the population of individuals with severe LTMI, role of the VR counselor, service models or organizational approaches to facilitate successful rehabilitation, community resources available, unresolved interagency problems surrounding the delivery of rehabilitation services, and the process of interagency collaboration. Appendices contain a sample interdepartment cooperative agreement between a mental health agency and a vocational rehabilitation agency; definitions of severity classifications; a functional assessment chart; a resource assessment chart; a vocational rehabilitation plan; information on training for service providers; and descriptions of 49 organizational resources that provide information, advocacy, funding, research, and other services in the field of long-term mental illness. (Includes 55 references.) (JDD)

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Fifteenth Institute on Rehabilitation Issues

Enhancing the Rehabilitation of Persons With Long-Term Mental Illness

Arkansas Research & Training Center in Vocational Rehabilitation
University of Arkansas, Fayetteville • Arkansas Rehabilitation Services

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Fifteenth Institute on Rehabilitation Issues
Tampa, Florida • December 1988

Report from the Study Group on

Enhancing the Rehabilitation of Persons with Long-Term Mental Illness

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Reports of the Institute on Rehabilitation Issues are produced by the Publications Department of the Arkansas Research and Training Center in Vocational Rehabilitation; however, they are not based on any research projects of that Center. The documents represent the findings agreed upon by the Prime Study Groups of the IRI and the opinions of individual members who contributed various chapters in the report. These are not necessarily opinions indorsed by the ARTC-VR.

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Chairperson's Comments

The Institute on Rehabilitation Issues (IRI) was and continues to be, an interesting, educational, and challenging experience for any person in a helping profession. This process provides for a number of individuals to study and develop a resource and training document on a current topic of concern to rehabilitation and other related fields. Since 1947, IRI and its predecessors (Institute on Rehabilitation Services and Guidance Training Placement Workshops) have been important sources of information on numerous issues for all levels of personnel in rehabilitation and related agencies.

This study, Enhancing the Rehabilitation of Persons with Long-Term Mental Illness, reflects the intent and purpose of IRI to bring about the provision and delivery of better rehabilitation services to persons with disabilities. Without question, individuals with long-term mental illness (LTMI) have long been underserved by vocational rehabilitation. Although many reasons can be given for the deficits in the provision of services to this population, including resources, personnel, collaborative efforts and funds, it still does not change the fact that services have been inadequate.

The members of this IRI study group have endeavored to produce a document that can be used by state vocational rehabilitation, mental health, and private agencies to enhance services to this clientele. Relevant issues, including LTMI populations, historical perspective, collaborative efforts, program models, and unresolved issues, are presented. The prime study group recognized there is no panacea for services and that no one model will meet the needs of all persons with LTMI. With this in mind, the study group attempted to provide the type of information that would assist all agencies concerned to provide better services that, at best, would result in gainful employment or, at least, a higher quality of life for persons with LTMI.

The prime study group members included James West, Suzette Skinner, Mike Carney, Karen Danley, Jay Foreman, Robert Harvey, William Cochran, Linda Katz and Suzanne Tillman. A very special thanks to Douglas Rice of the Arkansas Research and Training Center in Vocational Rehabilitation for his unique style of leadership, for keeping the study group on task, and in meeting all deadlines. Many others have made significant contributions to the study including Roy C. Farley, Ruth Gullett, Sandra Parkerson, Janice Davis, Lou Tabor, and Sandra Long of the Arkansas Research and Training Center in Vocational Rehabilitation. Sincere appreciation is extended to these individuals for their assistance and support.

Carol Cato
Chairperson
15th Institute on Rehabilitation Issues

Preamble

In December, 1988, the 15th Institute on Rehabilitation Issues (IRI) held its meeting in Tampa, Florida. At that meeting a series of three documents was reviewed and critiqued by the Institute participants. One of those documents was the work of a Prime Study Group which had taken as its charge the production of a document devoted to "Enhancing the Rehabilitation of Persons with Long-Term Mental Illness." The focus of the document was on the rehabilitation needs of persons who are severely disabled by virtue of their long-term and persistent mental illness (LTMI) and how these needs could best be met. The Prime Study Group sought to produce a training/resource document which could:

1. be used by administrators and managers to enhance collaborative efforts between mental health (MH), vocational rehabilitation (VR), provider agencies and consumers;

2. provide information about programs and other available resources that could be used to enhance rehabilitation services to persons with LTMI;

3. address unresolved issues that continue to have a major impact upon successfully meeting the rehabilitation needs of persons with severe psychiatric disabilities.

Statistical data gathered from a variety of sources will justify present and continued concern with this group of consumers of rehabilitation services. It has been estimated that, at a minimum, some two million persons in the United States can be considered to be chronically mentally ill (Goldman, Gattozzi, & Taube, 1981). Many have spent the majority of their lives in mental institutions, and others have experienced repeated short-term hospital stays while remaining in the community (Rutman, 1987). Psychiatric illness ranks fifth among major disease categories contributing to limitations in activity (Kottke, Lehmann, & Stillwell, 1982). Of those nearly 1.5 million severely and moderately disabled persons with chronic mental illness (CMI) who reside in the community, some 550,000 receive Supplemental Security Income (Anderson, 1982). In fiscal year 1985 (RSA-IM-88-23, 1988), of those 218,039 persons successfully rehabilitated nationally through the Federal-State VR system, some 10,778 or 4.9% fell in the category of persons with severe psychiatric disabilities (RSA Code 500, Psychosis). When the entire 500 series is considered, the number of persons in VR agency caseloads across the country amounts to nearly 40%. The "rehabilitation rate," or ratio, between the number of 26 closures (successfully rehabilitated status) and the total number of active cases closed for persons in the 500 category (Psychosis) was 47%. This figure compares unfavorably with the 66.3% rehabilitation rate for all other primary disability categories, and the 55.8% rate for the entire 500 series. The 500 series includes all mental and emotional conditions.

Alcoholism, drug dependence, mental retardation, and autism are also a part of the RSA 500 series. This 47% is the lowest success rate for any of the disability categories and is almost identical to statistics compiled from RSA data between the years 1973 and 1977 (Shelly, 1980). Finally, it has been ascertained that less than 15% of those persons with severe psychiatric disabilities are successfully employed at any given point in time (Anthony and Blanch, 1987).

In 1978, the Fifth Institute on Rehabilitation Issues published a study on the "Vocational Rehabilitation of Persons with Mental Disorders." That document was prepared "specifically for the state VR agency counselor...to assist in working with persons with mental disorders..." and "as a core document for in-service or short-term training." While the Fifth IRI Document dealt with the rehabilitation process and considered the characteristics of specific mental disorders, the focus was on work and work-related activities as the only legitimate outcome objective of the rehabilitation process. There appeared to be an underlying assumption that the process of VR began once the process of active psychiatric treatment, except for the provision of medication, came to an end. The concept of the LTMI disability reflected a traditional physical medicine approach toward VR. This approach required either a state of restoration or complete remission of the mental illness disorder.

In 1980, the Fourth Mary E. Switzer Memorial Seminar was devoted to "Rehabilitation of the Mentally Ill in the 1980's." The focus of that publication was to provide a "deeper understanding of mental illness: its causes and complications, and the challenges presented by this disability." This document came on the heels of the National Institute of Mental Health and Rehabilitation Services Administration Cooperative Agreement signed in May, 1978, which explicitly recognized the long-standing and severe nature of the disability whose "rehabilitation" would require the cooperation and collaboration of diverse service delivery systems over time. This document relied on Lamb's (1977) ten principles of "community rehabilitation." These ten principles follow:

1. Rehabilitation should be primarily in the community.

2. The rehabilitation plan needs to be comprehensive, including social and vocational rehabilitation, individual or group psychotherapy, psychoactive drugs if needed, financial assistance and the provision of a supportive living arrangement if required.

3. A high priority should be given to learning "in vivo."

4. The goal is to focus on the healthy personality.

5. The focus should be reality factors rather than intrapsychic phenomena, and on changing behavior rather than changing basic character structure.

6. In working with chronic patients, high but realistic expectations must be maintained so patients can strive to attain their full social and vocational potential.

7. Rehabilitation efforts should be aimed at giving patients a sense of mastery over their internal drives, their symptoms, and the demands of the environment.

8. An "institutional alliance" develops among psychiatric patients in which they relate more to the institution than to an individual.

9. Relatives are more to be relied upon as primary care agents.

10. Rehabilitation goals must be clearly defined in each phase of rehabilitation.

Grantham, 1980, (p. 2-3).

This expanded definition has been codified in the Independent Living standards and regulations that are a part of the Federal Rehabilitation Act and its Amendments.

This IRI Study Group recognizes rehabilitation as a comprehensive process which encompasses the identification of multi-systems, their interactions, and the active participation of persons with long-term and persistent mental illness. The intent of the Prime Study Group was to address this expanded definition and understanding of rehabilitation as a process in so far as the needs of individuals with LTMI are concerned.

The document examines those three components of the VR process -- the client, the counselor, and the programs -- and the systems through and in which the three major components interface and interact. Specifically, chapters focus on questions raised by the following topics:

1. The client:

   How do we define the population of individuals with severe LTMI?

2. The counselor:

   What is the role of the VR counselor in serving individuals with severe and persistent psychiatric disabilities?

3. The programs:

What service models or organizational approaches have been used to facilitate the successful rehabilitation of persons so disabled?

What community resources may be available to provide programmatic information, technical assistance, consultation, etc., regarding the successful rehabilitation of persons with severe psychiatric disabilities?

4. The systems:

How does our knowledge of the history of the VR process, the MH system of service delivery, and major provider agency endeavors contribute to a current understanding of unresolved interagency problems and conflicts surrounding the delivery of rehabilitation services to this group of consumers?

What do we know about the process of interagency collaboration and its effects upon the rehabilitation process?

What major unresolved issues have the potential to adversely affect "the enhancement of the rehabilitation of persons with LTMI"?

Chapter 1

History and Evolution of the Vocational Rehabilitation and Mental Health Delivery Systems

INTRODUCTION: In the last ten to fifteen years rehabilitation has been recognized as a valid goal for the client with LTMI, equal in importance to symptom control (the term symptom control is used in this chapter to include both reduction and control). Development of the skills needed to function successfully in all environments through rehabilitation services is not incompatible with emphasis on symptom control; rather, the two are mutually dependent. Unfortunately, efforts to coordinate rehabilitation goals with symptom control goals are less than successful because of the differences between VR and MH in legislation, funding patterns, missions, training patterns and human service delivery philosophies.

This chapter is devoted to tracing the history of VR and MH systems and the concomitant evolution of the values and attitudes of the professionals involved in the systems. The chapter seeks to identify how differences have evolved and how these have contributed to a lack of coordination in attaining rehabilitation and symptom control goals.

CHRONOLOGY: The presentation of the chronological history of VR and MH systems is done on a decade-by-decade basis beginning with the 1940's. This chronological review leads up to the present practices and issues facing both systems, and a discussion of how these systems can interface to provide maximally effective services to individuals with LTMI.

Decade of the 40's

In mental health the use of large, institutionally based treatment programs was reaching an apex during this decade. Since effective psychotropic drugs were not yet available, other treatment methods were used, including work as therapy. Ideally, large institutions were considered valuable as places of refuge and intensive treatment centers. And, theoretically at least, work was used to promote symptom reduction rather than as an end in itself.

In reality, large institutions could not have functioned without client labor and there were some situations where work was exploitative rather than used as a means for teaching job skills. Further, it was becoming apparent that institutions were deteriorating from public neglect, overcrowding and isolation--they were coming to be considered as places for maintaining behaviors, not for controlling symptoms. These conditions became the seeds for future reform.

The Barden-LaFollette Act of 1943 authorized services through the state-federal vocational rehabilitation system for individuals with mental illness and mental retardation; services prior to this legislation had focused on individuals with physical disabilities. It took at least a decade to implement this legislation and, as a result, vocational rehabilitation services for people with psychiatric disabilities did not really develop to any extent until the 1950's.

How do the events of the 40's still influence services to clients with LTMI? One way is through lingering attitudinal issues. Although VR programs have long had legislative authority to serve individuals with mental illness, one may still encounter the attitude that persons with more severe forms of illness, i.e., LTMI, are not feasible for VR services. Also, in spite of strong efforts to establish community-based services and psychosocial rehabilitation programs, a large portion of available resources continues to be used to support institutions, even though the patient census in such settings has declined dramatically over the years.

Decade of the 50's

Two events occurred that changed MH treatment as we know it: the advent of psychotropic medications, and the establishment of the Joint Commission on LTMI and Health in 1955. These marked the beginning of significant shifts in policies and practices regarding services to the MH client population.

Although institutions reached their maximum census of 560,000 persons during this time, the use of psychotropic medications resulted in a shift toward rapid and early discharges. Furthermore, MH professionals were defining their expertise as the eradication of psychiatric symptoms. Eradication of symptoms sometimes became identical to the concept of a "cure," and medication for psychotics was seen as a method to "settle clients out" so that they could participate meaningfully in therapy. The approach used in psychoanalytic schools further led to the belief that cures could take a number of years when psychoanalysis was the method of treatment.

The practical implementation of the 1943 VR legislation as it applied to the mental health population began taking place in the mid 50's. In addition, VR amendments in 1954 provided for rehabilitation research and training resources that helped accelerate services to people with mental disabilities. The late 50's saw the establishment of residential VR units on or adjacent to state mental

hospitals, and professionals were recruited to deal with social and work adjustment to facilitate post-hospital adjustment.

For VR, progress was made in increasing and expanding services to all psychiatric disabilities. Because community-based services were not in place to any extent, the client mix in state hospitals included a large number of disorders other than psychosis. Thus, persons served by VR were more likely to have less severe disabilities because of the "reasonable expectation" component of VR eligibility. For MH, this was the beginning of over reliance on medication-based treatment. Ironically, placing VR facilities on state hospital grounds produced mixed results for coordinating MH symptom control-oriented treatment approaches with vocational services. On the one hand, VR professionals interacted with and coordinated directly with MH professionals. On the other hand, the MH symptom-control orientation was reinforced and vocational goals, becoming a VR responsibility, took on less direct relevance. In some ways the separation between VR and MH goals took place, resulting in less common commitment to coordinated services.

Decade of the 60's

Two events in the 60's accelerated the trend toward deinstitutionalization. One of these events was a Supreme Court decision that established the "clear danger" criterion, which made it much more difficult for states to commit people to involuntary inpatient treatment. The other important event was the Mental Health Centers Act of 1963. A Product of the Joint Commission established in 1955, this act led to the establishment of Community Mental Health Centers (CMHCs). Because of the concept that MH professionals could be more effectively utilized than they had been in the past, the medical model was losing some of its allure as the treatment of choice. Consequently, the goal of the CMHC was to provide support in the community for severely mentally ill persons who were returning from state hospitals.

What actually happened, while a step in the right direction, fell somewhat short for a variety of reasons. First, those people being trained as basic MH professionals were focusing on diagnosis and treatment instead of facilitation of social competency. In fact, the belief was, "If I treat the dysfunctional personality structure (through various forms of psychotherapy and medication if needed), then the social competency will fall into place."

Second, the census of the state hospitals was declining because people were receiving community-based services. However, a good portion of the decline was due to the fact that non-psychotic, less severe cases were now receiving services more appropriate to their needs. Also, MH professionals, when confronted with post-graduate school reality, learned quickly that the more severely disabled clients did not respond well to "talk" therapies. As a result, clients with the more severe disabilities received less intense services--primarily medication, crisis intervention, and screening (follow-up after state hospital services), and CMHCs progressively became more oriented to promoting the "private practice" model for those clients who had some verbal skills. To some degree, this trend continued throughout the next two decades.

Later, amendments to the Vocational Rehabilitation Act expanded research and demonstration projects directed toward services for people with LTMI. These projects included work-therapy centers for persons hospitalized with LTMI, replication of the Fountain House model, and use of long-term, sheltered workshops.

In 1965, extended evaluation was implemented as a legitimate case status. In addition, federal regulations implementing 1965 amendments defined behavioral disorders without psychiatric terminology, thus opening the program to many who would not otherwise have met program criteria.

Even though VR services were expanded to parallel efforts in MH, they still did not meet all the needs of persons with long-term, severe mental disabilities. This was due to two sets of circumstances.

First, the VR agencies were establishing concurrent services in the state hospitals, sometimes in the form of residential units. However, since the MH professionals saw work adjustment and vocational competencies as separate from what they did, the VR professionals often operated independently within the MH settings and, typically, dealt with clients who had less severe disabilities.

Secondly, pursuit of the successful closure (Status 26) was coming to a head at this point. Rehabilitation had a status system under which state agencies often sought a certain number of successful closures (clients placed in a job for a certain length of time) on the part of each VR counselor. This discouraged counselors from working

with clients who had the most severe disabilities because more time and resources were needed to bring them to successful closures. This led to the accusation that rehabilitation professionals were "creaming" the psychiatric clients with less severe disabilities in an effort to produce higher success rates.

Decade of the 70's

Many of the trends begun in the 60's by the CMHCs were further reinforced in the 70's. Those catchment areas that implemented CMHCs often did so by the late 60's and early 70's; and by the end of the 70's, the original funding grants usually had run their eight-year course. The expectation was that the CMHCs were to be "self-sufficient" by the end of their grant cycle, either by generating fee-for-service or local support.

In reality, the state typically stepped in at this point and took over a greater share of the funding; and, by the end of the 70's, the CMHC movement had gathered a great deal of momentum and political clout. However, it was believed that state funding alone could not sustain the activities of the CMHCs. It was also recognized that CMHCs often were not providing the hoped-for services to people with the more severe disabilities, largely because of the "private-practice" mentality. Thus, a variety of important activities, again aimed at severe disabilities, were started in the 70's.

In 1977, the National Endowment for Mental Health (NEMH) began the Community Support Program (CSP), designed to encourage a comprehensive approach to providing all needed community services to persons with LTMI. The focus was on those persons who were, or would be, inappropriately institutionalized, and the services included housing, job training, and social services. Philosophically, the program recognizes the mutual dependency between rehabilitation goals and symptom-control as opposed to mutual exclusiveness. In fact, the four components of a CSP are grants, technical assistance, interagency collaboration, and evaluation. Since the mid 70's, a cadre of MH professionals who focus their interest on severe illness has been slowly growing as a result of this effort.

A second and potent factor in the 70's was the coalescing of MH consumers with severe and chronic psychiatric illnesses and disabilities. This group began to bring pressure to bear on CMHCs and state hospitals to provide more effective services for clients with severe disabilities. This, along with the CSP, began slowly to shift

the focus of service from pure symptom control to rehabilitation.

Third, a variety of field models such as Fairweather Lodge and Fountain House in 1980 began providing data on the "psychosocial" rehabilitation approach which attempted to address the problems of persons with severe disabilities. A research and training center was established at Boston University in 1979 to identify successful approaches to LTMI and to provide formal training for professionals on psychiatric rehabilitation. While the efforts were sporadic and the results mixed, this third factor made the first formal statement that rehabilitation and treatment are not mutually exclusive objectives. The problem was, and continues to be, that MH professionals (spurred by CSP monies and consumers) took up "psychiatric rehabilitation" efforts for the most part. In general, a number of professionals working in psychiatric rehabilitation entered the field by accident or chance, and have not been adequately trained to the desired level for duties they have been assigned. Leaders in the field tend to agree that extensive/ intensive training programs are critical needs in this area.

In VR, a series of activities moved rehabilitation services one step closer to providing for persons with LTMI. In 1973, the Rehabilitation Act reflected a trend toward eliminating discrimination and integrating persons with disabilities into all aspects of society. Features of this Act included:

1. a strong mandate to serve persons with severe disabilities;

2. a strong mandate to involve clients in the planning and delivery of services;

3. establishment of Client Assistance Programs (CAP) as a discretionary program;

4. initiation of the Individualized Written Rehabilitation Program (IWRP); and

5. authorization of long-term training in rehabilitation counseling.

This act expanded the 1943 Act to mandate service to persons with severe disabilities. It was the result of protests by consumers who believed that rehabilitation

agencies no longer served people with severe disabilities. Although the accusation was made, it should be noted that the consumers who brought the issue to light had physical disabilities rather than psychiatric. (MH consumers, who for the most part had begun their treatment with MH agencies, were not a potent political factor until the last half of the 70's.) Consequently, the initial focus was again on physical disability to the unintentional detriment of persons with psychiatric disabilities.

Thus in 1977, the RSA project-grant program included the additional category of severe mental illness. A parallel between the MH and VR systems was established. After earlier efforts had not quite produced the hoped-for results, i.e., CSP for MH, the needs of persons with LTMI were not addressed legislatively along with the project-grant program for VR. Further efforts by VR came in 1978 when the VR Act was amended to:

1. add independent living to RSA discretionary programs,

2. reflect the beginning of a VR intervention model that shifts from client-centered (remediation) programs to environment-centered (accommodation) programs, and to

3. shift VR focus away from employability as the *only* acceptable outcome for VR clients.

Decade of the 80's

In the 1980's, three events dovetailed to continue a rehabilitative focus and a severely ill focus in MH. First, consumers learned to better utilize the political process for communicating their needs through such organizations as the Alliance for the Mentally Ill. As a group, they stated forcefully that neither of the service paradigms within VR and MH were meeting the needs of persons with LTMI. They were instrumental in focusing on the issues of symptom-reduction versus rehabilitation and fragmented, uncoordinated resources. They also pointed out that the VR concept of reasonable expectation often was not applied to persons with LTMI, and they emphasized the need for ongoing, lifetime, environmental supports. Other efforts for consumers were the establishment of Client Assistance Programs (CAPs) as formula-grant programs by RSA in 1984 and the expansion of focus by Protection and Advocacy (P&A) Agencies in 1986 to include persons with LTMI.

Second, CSP continued to expand it's focus. Notably, the National Association of State Mental Health Program

Directors (NASMHPD) has recently formed a division devoted to the concerns of community support programs. The name of the division is Community Support Program for Persons with Long-Term Mental Illness (CSPPLTMI).

The third significant event came from the state legislatures. As consumers expressed their dissatisfaction and as state funding became a larger issue, state governments began to press for increased and coordinated services to persons with LTMI.

In general, this has improved MH services for severe psychiatric disabilities in the 80's, but has not necessarily assured better rehabilitation services. The CMHCs that have staff with vocational backgrounds or other appropriate professional training are usually more successful. However, in order for a psychosocial approach to be fully effective, the term, "psychosocial," should be understood to include VR services as well as social services, and the CMHCs must be cooperative.

On the other hand, one other event reinforced the status quo (maintaining symptom reduction as a focus). This was the passage of the Block Grant which directly reinforced the notion that traditional treatment services are all that MH agencies must provide.

Regarding VR, several major events also took place. First, RSA responded by developing long-term training grants devoted to interagency coordination. Second, in 1986, amendments to the Rehabilitation Act of 1973 made a stronger commitment to severe disabilities and included psychiatric disabilities. This act includes:

1. development and implementation of Supported Employment,

2. Transitional Employment for persons with LTMI,

3. inclusion of psychosocial rehabilitation programs in the definition of rehabilitation facilities, and

4. acceptance of part-time work as a valid vocational outcome.

Additional rehabilitation efforts are in the area of Independent Living (IL) programs and in the location of VR staff in community mental health facilities. The growth of the IL movement reflects a change in thinking that emphasizes disability as an environment-centered problem rather than client-centered.

Nevertheless, IL programs still focus on environmental accommodations needed by those with psychiatric disabilities. However, supported employment, particularly the job coach concept, represents an effort to accommodate the environment relative to cognitive disabilities.

SUMMARY: Continued deinstitutionalization of residents of mental hospitals has led to a shift in co-location of VR from mental hospitals to CMHCs. During a recent survey of state VR agencies, 34 state VR agencies report co-location of VR staff at MH facilities, with 11 agencies reporting current or future statewide implementation of co-location.

As the 1980's draw to an end, a variety of activities aimed at enhancing the employability of persons with LTMI have been developed. Examples of these are:

* Supported Employment Project Grants. These grants are aimed at developing vocational services primarily for persons with developmental disabilities and LTMI. The specific projects are often located within MH programs and utilize job coaches.

* Joint Vocational Rehabilitation/Mental Health Agency Training. Training that facilitates cooperative relations between these two agencies is now beginning on a nationwide basis.

* Expansion of Private Non-Profit Programs. These programs typically utilize a variety of vocational options to meet the needs of clients with LTMI. (See Chapter 3.) Given the nature of their symptoms, LTMI clients often cannot respond to eligibility systems that have a highly linear organization, but these new programs have greater flexibility in terms of meeting client needs. Usually, these programs can procure funding from a variety of resources (including MH and VR) without arousing turf boundaries.

* Robert Wood Johnson Project. Designed to produce standards for clubhouse models (Fountain House), this project provides training for establishing clubhouses and expands the number of clubhouses nationwide.

* Consumer Empowerment. This insures continued emphasis on psychosocial rehabilitation models that reinforce a consumer-oriented and consumer-driven focus. Some of the results have been expansion of P&A and CAP agencies, pilot testing of voucher systems so that

consumers could purchase their own services, and utilization of peer counseling for job clubs.

To summarize, at the end of the 70's and during the 80's, the concept of community-based programs with a psychosocial rehabilitation focus was established. It can be anticipated that this trend is not just another fad that will fade, but a significant evolution in the treatment and rehabilitation of persons with LTMI.

Chapter 2

Description of Population and Needs

INTRODUCTION: The needs and problems associated with LTMI are multiple and complex. This chapter provides a review of several important issues in addition to describing problems and needs. Definitional issues plague this population, and some issues are summarized so that the reader may appreciate the difficulties encountered with the population. In addition, a systematic review of needs is essential to understanding the problems and designing responsive service delivery systems to address the needs. One of the primary issues in a discussion of needs is the perception by many people that the needs of persons with LTMI are somehow different from others. This chapter represents an effort to summarize the most salient needs and some of the problems encountered in delivering services to people with LTMI.

DEFINITIONAL ISSUES: Much effort in recent years has gone into deriving a definition of LTMI. This has been done in part to enable state program planners to assess the incidence of the problem and service needs of the population. Three circumstances have created difficulties in arriving at a widely-accepted definition. First, no definitive subset of diagnoses comprises the population with LTMI through sources such as the American Psychiatric Association: Diagnostic and Statistical Manual (1987). Only those diagnoses with a higher probability of association with LTMI can be considered. Second, functional limitations in living, learning, and working environs are not specific at the group level, i.e., individual clients have different types and amounts of functional limitations. Also, functional limitations are only moderately associated with diagnostic types, e.g., a person with a borderline personality disorder may have more functional limitations than a person with a schizophrenic disorder. Finally, there has been a demographic shift in the population from older, institutionalized and chronic clients to younger, noninstitutionalized chronic clients.

Nevertheless, working definitions are essential to the effective delivery of services for people with LTMI for a variety of reasons. Definitions provide the foundation for problem descriptions and service delivery design. In essence, the definitions outline the parameters of the problems and the targets for service delivery interventions. Without accurate definitions of the problems under consideration, it is possible to direct services toward less severely disabled individuals who may be viewed as easier to serve, or at least more feasible for services. Thus, clarification of definitions guides the formation of policies and practices to resolve a particular problem, and murky definitions result in murky

policies, often directed toward the less severely disabled populations.

Two types of processes are used to define persons with LTMI: criteria-based and process-based definitions. Criteria-based procedures tend to focus on factors considered to be uniquely related to the entity being defined. These factors become criteria for inclusion in the definition. In regard to LTMI, the typical factors are diagnosis, duration of illness, services needed, supports needed, and functional limitations. Examples of this approach can be found in both the National Institute of Mental Health (NIMH) and the Rehabilitation Services Administration (RSA) policies. For example, the extension of the Rehabilitation Act of 1973 (P.L. 99-506) defines the severely handicapped person as having:

> ...a severe physical or mental disability which seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of employability; whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time and who has one or more physical or mental disabilities resulting from...(a list of specific conditions including mental illness follows).

The NIMH definition emphasizes diagnosis, disability and duration.

> The CMI population encompasses persons who suffer certain mental or emotional disorders (organic brain syndrome, schizophrenia, recurrent depressive and manic-depressive disorders, paranoid and other psychoses, plus other disorders that may become chronic). These are disorders that erode or prevent the development of functional capacities in relation to three or more of such primary aspects of daily life as personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning, and recreation, and that erode or prevent the development of economic self-sufficiency. Most individuals so diagnosed have required institutional care of extended duration, including intermediate-term hospitalization (90 days to one year in a single year), long-term hospitalization (one year or longer in the preceding five years), nursing home placement for a diagnosed mental condition or diagnosis of senility without

> psychosis. Some such individuals have required short-term hospitalization (less than 90 days), others have received treatment from a medical or mental health professional solely on an out-patient basis or, despite their needs, have received no treatment in the professional-care service system. Thus, included in the target population are persons who are or were formerly "residents" of institutions (public and private psychiatric hospitals and nursing homes) and persons who are at high-risk of institutionalization because of persistent mental disability. (US Department of Health and Human Services, 1980, pp. 2-11).

As can be seen, the NIMH definition indirectly acknowledges that psychotic conditions (organic brain syndrome, schizophrenia, major affective disorders and other psychotic disorders) are most likely to be associated with chronicity and severity. However, this is not a one-to-one relationship. Disability is defined in terms of functional limitations in living, learning, and working environments. Duration is defined either in terms of length of actual treatments received or treatments for which the person is "at risk."

In addition to these definitions, all state MH authorities have a definition of chronic mental illness (now more commonly referred to as LTMI). In a review of these definitions, it was found that much variability existed among the states. For example, some diagnoses were extended or even excluded. Those most likely to be excluded were organic brain syndrome, mental retardation and some drug/alcohol abuse categories.

While criteria-based definitions address the elements that characterize a condition, process-based definitions use a review procedure to determine if a person can be considered as having LTMI. For example, in Arkansas a clinical case reviewed by a MH professional is used to determine eligibility for specialized services for individuals with LTMI. The criterion areas of diagnosis (usually psychosis), duration (receipt of services for more than six months or an expectation of same), and disability (functional limitations in daily living, work, and symptom severity) are guidelines for inclusion, as opposed to clear-cut criteria. While this method recognizes that persons with LTMI have, within broadly described boundaries, a range of characteristics, it also recognizes that categorization is at best a global, multivariate judgment that is difficult to specify precisely.

In summary, while definitional methods often share broad-based similarities, these do vary significantly. One important practical result of this variation is the way in which resources are allocated as a result of the definition. For example, if a state MH authority excludes a diagnostic category, the target population is reduced and resources may be more restrictive. In addition, definitional issues may be a problem in identifying appropriate referrals to other agencies, such as VR. Therefore, definitional issues need to be clarified and resolved so that those individuals with LTMI in need of a comprehensive array of services are served effectively.

NEEDS:

As can be seen in need statements such as that provided by Rutman (1987), the needs of the LTMI group are the same as for everyone else, namely

- to secure material resources such as food and shelter,
- to obtain medical care in the community,
- to learn coping skills to meet the demands of daily living,
- to be free of pathologically dependent relationships,
- to grow toward greater autonomy,
- to establish a social support system, and
- to learn skills necessary for vocational competence.

However, it is necessary to go beyond such global need statements to more clearly target service interventions.

Incidence

Using a criteria-based definition, NIMH estimated that there were between 1.7 and 2.4 million individuals with LTMI in the years from 1975 to 1977. These figures will likely be higher now assuming a fairly constant incidence rate and the fact that the last of the baby-boomers have reached the age that schizophrenia, the most frequently diagnosed LTMI, is manifested as a diagnoseable condition. This indicates a significant population of individuals in need of continuing services and support.

Characteristics

LTMI is generally considered to be a continuing condition with fluctuations in symptoms and functional limitations. As a result, there is a need to view treatment and care in terms of improved functioning rather than cure, with the goal being to maintain the individual at as high a functional level as possible. Because of the underlying disease, often combined with a lack of social and physical resources, most people with LTMI have difficulty handling even basic necessities of living. In addition to these problems, they need continuing interpersonal

support and assistance, and services to people with LTMI should focus on three environments: living (community, home, leisure), learning (school, job training), and working (job sites, volunteer activities).

More specifically, persons with LTMI demonstrate a wide array of cognitive, sensorimotor and emotional/coping dysfunctions:

- cognitive dysfunctions may include impairment of abstract attitude, concrete thinking, inability to make generalizations, misinterpretation of spoken/written language, poor attention and concentration, disturbance of memory and learning, slow processing of information, difficulty in categorizing and organizing input, poor fund of knowledge regarding deficit, poor fund of knowledge about world of work, slowed ability to learn new skills, inability to evaluate work quality and lowered cognitive abilities due to medication;
- sensorimotor dysfunctions include unusual fatique, psychomotor abnormalities and hallucinations; and
- emotional/coping dysfunctions include lack of motivation, failure to persist in tasks, inability to get along with others/supervisors, lack of initiative, lack of eagerness at work, lack of impulse control, reduced ability to tolerate stress and change, poor hygiene and self-care, poor medication compliance, reduced ability to manage personal affairs, and poor general daily living skills.

The above list of problems of functional deficits demonstrates the need for a broad array of supports and services, generally more than any one service agency can provide in a coordinated and effective fashion.

Service Delivery System Needs

The service provider focusing exclusively on one set of treatment/rehabilitation goals cannot usually meet all of the needs presented by the individual with LTMI. For example, the goal of symptom control through hospitalization is more likely to be accomplished for longer periods of time if the client is functioning as well as possible at work and is living in adequate housing. Therefore, the achievement of reasonable functioning across living, learning and working environments, requires several rehabilitation and support services including:

- independent living - general daily living activities, e.g., cooking, cleaning, personal hygiene,

budgeting, shopping, transportation, use of telephone, first aid, leisure time and socializing;

- education - basic academic skills, study skills, attending class on time, etc;
- vocational adjustment - work adjustment training, social skills training, job seeking/retention skills, job development and placement, vocational evaluation, vocational skills training, job coaching, etc.; and
- support services - medical services, medication, psychotherapy, income, housing, transportation, and client-centered case management.

In addition to the provision of services such as these, persons with LTMI may respond dysfunctionally to human service systems. Given services based in multiple public and private agencies, many individuals with LTMI find it difficult to execute the complex responses to interact effectively with the typical service delivery system. Therefore, it is necessary to address how to make these services available to this population.

A review of many programs indicates that certain concepts should be included if the process is to accomplish its objectives. These concepts are discussed throughout the document and include identifying clients with LTMI as a specific population; coordination with other service providers, trained professionals and community-based facilities; and treatment of each person as an individual. Other factors that should be considered are easy accessibility to inpatient and outpatient care along with an ongoing evaluation of the effectiveness of programs and services.

SUMMARY: This chapter has addressed definitional issues related to the concept of LTMI and the needs experienced by this population without over-reliance on fixed criteria. A combination of criteria- and process-based definitions appears to be required to more adequately address this population's needs. In addition, the functional limitations frequently associated with LTMI require an understanding of the dysfunctions that have to be dealt with in service interventions. Specific services have to be designed or adapted to facilitate accommodations to living, learning and working environments. Also, a clear understanding of the problems these individuals have in interacting with the complex human service system is required by the designers of such programs.

For people with LTMI to have a reasonable chance of coping with the typical demands at home and work on a

daily basis, it has been demonstrated that they must have an array of community-based supports and services.

Chapter 3

Interagency Collaboration and the Rehabilitation of Persons with Long-Term Mental Illness

INTRODUCTION: The rehabilitation of persons with LTMI continues to be among the most problematic and challenging of issues that confront the VR and MH systems in this country today. The needs of these persons extend well beyond the boundaries of any one system and require coordinated efforts with a broad array of health and social welfare agencies. Long-term commitments on the part of local agencies and the clarification of lines of responsibility for them at all levels of government are problematic (Morrissey, Tausig & Lindsey, 1985). Moreover, the nature of the disability itself, the inadequacy and inappropriateness of existing programs, and resistance from professionals as well as potential employers contribute to the substantial problems associated with productive employment for these persons. While both the VR and MH systems may agree on the problems, solutions are complicated. They depend on the cooperation of direct service providers; local and state-level policy makers; and administrators with fiscal responsibility who must determine eligibility, length of service, appropriateness of programs, etc.

In an effort to address these inter-system concerns, NIMH signed a cooperative agreement in 1978, with RSA, pledging to assist in broadening areas for collaborative activity aimed at enhancing the rehabilitation of persons with LTMI. The federal agreement encouraged the development of similar state-level agreements, the possibilities for joint funding of programs and projects, and the initiation of joint training activities for interagency personnel.

In order to understand the status of interagency collaboration in the rehabilitation of persons with LTMI it will first be necessary to look at the historical roots of the process. This chapter will trace the development of interagency collaborative efforts in the human services arena by reviewing the factors identified as either barriers or facilitators of the process. Next, studies relating to collaboration between the federal/state VR system and the MH system in providing services to persons with severe and persistent LTMI will be addressed. Work funded through RSA in the area of long-term training in interagency collaboration will also be presented. Finally, implications drawn from the training experience will be presented along with examples of state interagency agreements. These may serve as models for agencies or organizations interested in designing and implementing interagency agreements on behalf of the rehabilitation of persons with LTMI.

Basis for Collaboration

There is a long historical and philosophical basis for collaboration and cooperation among human service organizations. Most of the work comes from the fields of special education and organizational theory (Elder & Magrab, 1980; Gutterman & Todd, 1981; Baumheier, 1982; Broskowski, Marks, & Budman, 1981; Gugerty & Getzel, 1982; Johnson, McLaughlin, & Christensen, 1982; Martinson, 1982; Morrissey, Tausig, & Lindsey, 1985; Flynn & Harbin, 1987; Peters, Templeman, & Bostrom, 1987; and Stodden & Boone, 1987).

Although the roots of organizational cooperation and linkage in the field of human services can be traced back to earliest American history (Attkisson & Broskowski, 1978), serious and systematic attempts at understanding methods of interagency coordination were not developed until the late 1950's and early 1960's. With the growth of human services after World War II, planners, evaluators, and administrators became more sensitive to the complexity of interorganizational relationships that emerged when different agencies were required to work together in meeting the needs of multiproblem clients. Increasing scholarly interest in interorganizational relationships began in the 1960's, when system-theoretical approaches were used to explain the relationships between a focal organization and the environment of other organizations and groups with which it interacted (Broskowski, Marks, & Budman, 1981).

Under the rubric of systems theory, Broskowski et al. concluded that MH services are experiencing rapidly diminishing federal support. This leads to ambiguity and some realistic pessimism about the willingness and ability of state governments to fill the resulting gaps in support. In order for these service agencies to exist, the agency must either have in place, or be willing to develop, a successful program of interorganizational linkages. Such linkages are viewed by these authors as strategic for dealing with the prospect of diminishing resources. In this context, establishing interagency linkages is viewed as a logical undertaking since the motivating factors for such collaborations among human service organizations and professionals have, over time, involved concerns with survival and growth, efficiency, risk reduction, specialization, and stability.

Johnson, McLaughlin, and Christensen (1982), like Broskowski et al., blame the attention focused on interagency collaboration since the late 70's on certain economic mandates and constraints. These factors impelled

the need to capitalize on the "largest number of resources at the smallest cost in the provision of services to handicapped children and youth" (p. 395). Public Law 94-142, the Education of All Handicapped Children Act of 1975, gave additional impetus to the interagency movement in the field of special education through the provision of the related service requirements of the law...

> Transportation and such other developmental, corrective and supportive services as are required to assist a handicapped child to benefit from special education...
>
> Certain kinds of services that might be provided by persons from varying professional backgrounds and with a variety of operational titles... (pp. 42479-80)

Moreover, Martinson (1982) viewed interagency collaboration as particularly integral for serving persons with handicapping conditions because of the history of specialization in the field. He wrote: "Interorganizational dependency is a logical corollary of organizational autonomy and specialization. The general tendency to attempt remediation of service-system deficiencies via agency-specific authorizations generates the need for interagency program models" (p. 389).

Setting the Stage for Interagency Collaboration

Flynn and Harbin (1987) presented a paradigm for the evaluation of interagency coordination efforts. While founded in the special education field, the paradigm, nevertheless, serves as a model for the development of the interagency process. Figure 1 outlines the stages of development in this model. It answers several questions: who will be involved in the process? (formulation); what is the rationale for such a process? (conceptualization); how will the process be implemented? (development); and what are the expected outcomes? (implementation).

Figure 1

Developmental Stages In The Interagency Collaborative Process

FORMULATION	CONCEPTUALIZATION	DEVELOPMENT	IMPLEMENTATION
Capable person selected to conceptualize and provide leadership	Written mission statement	Development of work group	Interagency agreement developed
Selection of group members	Assessment of current systems/development of goals, objectives and working strategies	Development of an adequate system of communication which allows input by all and results in a feeling of ownership	Policy changes made to eliminate former barriers
Selection of facilitator/ leader	Selection of a decision-making model	Communication with key decision makers	Attitudes of agency personnel more positive and cooperative
Development of structure for communication	Define tasks, roles, responsibilities, and timeliness	Work groups address and resolve issues and conflicts	Services improved
Development of a climate for active participation	Development of a system of communication	Examination of all relevant agency policies	More clients served
Delineation & understanding roles/responsibilities	Determine administrative structure for future interagency efforts	Plans facilitate revising and/or expanding the system	Contacts and communication occur as planned
Acceptance of level of group authority	Approval of plans by high level decision makers	Approval of plans by the group as a whole	Strategies selected to enhance interagency functioning
Knowledge of members acquainted with one another and programs	Public awareness and support		Participants interact productively, resolving conflicts as they arise
Agreement on a global mission	Development of a strong group identification		
Potential conflicts identified	Mechanism for coordination with other groups		

Writers in both special education and human service organizations also have recognized strategic levels of operations and functions within and between organizations where linkages or interagency collaboration can occur. These were identified by Baumheier (1982) under the categories of policy management and planning, administration, and direct service. Six specific functions addressed by these three categories, and ways they might be put into operation are summarized in Figure 2.

Figure 2

POLICY MANAGEMENT & PLANNING	ADMINISTRATION	DIRECT SERVICE
* *Planning & Programming*	* *Fiscal*	* *Core Services*
- Joint policy formulation - Sharing access to records - Common data base	- Joint funding of projects - Joint purchase of services - Use of voucher system	- Joint outreach/ intake - Joint evaluation and referrals - Shared follow-up service
* *Support services*	* *Personnel*	* *Case Coordination*
- Joint record keeping - Shared use of facilities and equipment - Shared use of clerical or consulting services	- Co-location of staff - Shared use of staff - Joint staff meetings - Joint training	- Joint case conferences - Interagency teams - Shared case management - Joint case consultation

Factors that Facilitate or Impede the Collaborative Process

Driving Forces. Within these overall categories in which interagency collaboration may occur, some "driving forces" (Isaacs, 1983 p. 13) have been identified which appear to relate to the quality and effectiveness of that collaboration. Johnson, McLaughlin, and Christensen (1982) have identified the following factors which can promote this interagency process:

Figure 3

Johnson et al.	Broskowski et al.
- Pressures from clients, parents, & advocates	- Survival & growth: guaranteeing a minimum or increasing the level of critical resources, including clientele
- Federal initiatives	
- Economic pressures	- Efficiency: avoiding unnecessary duplication of expensive functions
- The need to reduce and/or eliminate duplication of services	- Risk reduction: pooling efforts to meet high start-up costs and to share risks
- The continuing development of new and improved treatment strategies	- Effectiveness: providing all needed services to multi-problem clients by pooling specialized skills
- Inter/intraprofessional pressures, based on the need for continuing education	- Specialization: meeting infrequent demands for highly specialized functions that cannot be justified or attracted internally
- Fragmented service delivery systems	- Stability: monitoring & predicting increasing environmental turbulence through planned linkages
- Overlap in service definitions	
- Multiple funding bases	- Preferred strategy: espousing cooperation rather than overt competition is a tradition among human service professionals
- Multiple planning bodies	
- Varying models for services delivery	

Contextual Conditions. Other writers (Molnar & Rogers, 1979) have suggested a number of conditions that determine the level of independence and areas of conflict between groups. These include:

1. the clients served

2. the services provided

3. the sectors of involvement in the interorganizational field

4. the common relations to a higher organizational authority

5. the common relation to a coordinating body

6. the relative age or length of service

These investigators reported that organizations sharing client groups and operating sectors tended to report higher levels of conflicting responsibilities and priorities. Most of the interagency conflict was attributed to inconsistent agency purposes and mandates, and not to the terms and conditions of interdependent relations. The authors concluded that coordination is most likely to occur on the basis of problem area involvement.

Boje and Whetten (1981) examined client referral networks in 17 communities to determine the influence of organizational strategies and the contextual constraints on location in interorganizational transaction networks. As a result of their study, five propositions were verified regarding the centrality of an organization in a network and the attributed influence such agencies have in these interorganizational networks:

1. Joint program strategy increases client flow through an organization and enhances its attributed influence.

2. Strategic formal and informal communication linkages increase both an organization's knowledge of critical contingencies affecting its attributed influence and its client intake and output options.

3. Larger organizations, in terms of number of staff members and number of services offered, will be less constrained in obtaining and making client referrals and will consequently have more attributed influence.

4. Organizations more geographically proximate to other community organizations will receive more referrals and consequently have more attributed influence.

5. Organizations having a greater number of imposed relationships with other organizations will be more likely to be central but will have less attributed influence.

Potential Barriers. In addition to these facilitative factors, a number of potential barriers to the process of interagency collaboration were identified by Johnson et al. (1982). Among these were variability and inconsistency in the definition of roles and responsibilities of staff across and within agency organizational structure, difficulty in the identification and selection of personnel to deliver services, and staff turnover, resulting in key positions filled by individuals not committed to the process. Barriers identified by Johnson et al. are highlighted below:

1. public versus private agency participation

2. interpersonal relations between and among planning board members

3. disagreement on target populations

4. lack of centralized information base

5. imprecise definition of agency responsibility and authority

6. absence of common procedures for information dissemination

7. difficulty in defining decision-making rules among developers

8. fragmented fiscal support for interagency efforts

9. confidentiality and transference of records

10. absence of provider acceptance/understanding

11. uncertainty of end product

12. lack of sustained availability of key people to facilitate planning

13. variability in client eligibility

14. resistance to change among agency consumer members

Elder and Magrab (1980) looked at factors inhibiting interagency collaboration in the field of special education, as well. They identified and summarized them in terms of the following factors:

1. disagreement on the target populations

2. imprecise definition of agency responsibilities

3. absence of the common procedures for information dissemination

4. uncertainty of the end product to be achieved

5. variability in client eligibility for services

6. an absence of an understanding or willingness on the part of provider agencies contracted to provide specific services

Mitigating Conditions. Having reviewed those factors that appeared to facilitate the process of interagency collaboration and those which had been identified as inhibiting that process, Broskowski et al. (1982) concluded that certain conditions affecting any number of specific factors determine whether these factors will help or hinder the process of collaboration. These authors grouped factors into three categories: environmental conditions, intraorganizational conditions, and interorganizational conditions.

Examples of environmental conditions are:

- resource amount
- resource location
- rate of change
- complexity
- predictability

If resources are abundant, the effect on interorganizational relationships will not be critical. If resource locations are organized, the result will be positive.

Intraorganizational conditions involve:

- control over resources
- leadership style
- core technology
- information capability

If control over needed resources within a given organization is significant, the effect on interorganizational relationships will be inhibitory. If information capability is advanced, the effect will be facilitative. On the other hand, if leadership style is insular/orthodox, the resulting effect will be inhibitory.

The impact of interorganizational conditions on any number of variables can be either inhibitory or facilitative. Examples of the impact of these interorganizational conditions are illustrated below.

Figure 4

Variable	*Condition*	*Effect*
number of entities involved	if many	inhibitory
dependence	if reciprocal	facilitative
goals/domains	if competitive	inhibitory
philosophy/values	if identical	facilitative
complexity (size, structure, technologies)	if dissimilar	inhibitory
planning	if unilateral	inhibitory
implementation	if gradual	facilitative
commitment	if managed	facilitative
dimensions of exchange:		
benefits	if unequal	inhibitory
levels	if few	inhibitory
information	if mutual feedback	facilitative
rate	if frequent	facilitative
distance	if great	inhibitory

STUDIES IN VR/MH COLLABORATION

While the RSA-NIMH interagency collaborative agreement dates back to 1978, systematic investigations of the collaborative efforts between VR and MH are few in contrast to those focused in the area of special education. Cohen (1981), Dellario (1985), and Woy and Dellario (unpublished manuscript) from Boston University represent the majority of writings specific to VR and MH interagency collaboration. The work of Dellario is summarized as it illustrates the first such systematic inquiry to address the effectiveness of a process of interagency collaboration in terms of client/consumer outcome in the rehabilitation of persons with a psychiatric disability.

Dellario (1985) selected seven counties in the state of Oregon in which structured interviews were conducted with administrative and front-line staff from VR and MH agencies within each county. Data were then gathered from VR client records to determine if the nature and quality of the selected VR/MH interagency linkage could be differentiated on the basis of VR outcome indicators. The central question was whether those agencies with higher levels of interagency functioning also exhibited higher levels of VR outcome, i.e., 26 closures, acceptance rates, and competitive employment placements. While there were certain methodological limitations to the study, the results showed a number of trends with respect to interagency linkage and VR outcome data. The overall finding was that the probability of a successful VR outcome increased when clients were referred from agencies with good interagency linkages in place. This finding rested to a great extent on the operational definition of "good" interagency linkages. The qualitative aspects of these successful linkages appeared to be based upon mutuality of purpose and mutuality of respect between the agencies.

A significant aspect of mutuality of purpose between agencies was the recognition that the MH system acknowledged VR intervention as a legitimate MH service. If the VR needs of persons with psychiatric disabilities were to be met, Dellario concluded that the MH system must move in the direction of providing vocationally oriented and/or prevocational rehabilitation services.

TRAINING IN INTERAGENCY COLLABORATION WITH MH, VR AND PROVIDER AGENCY ADMINISTRATIVE PERSONNEL

Part of federal recognition of the need for joint training initiatives as an essential component of collaboration between the two (VR and MH) systems involved a series of training grants awarded through RSA and directed specifically toward VR, MH, and provider agency audiences. In 1984 and 1985 Western Psychiatric Institute and Clinic (WPIC), the Department of Psychiatry at the University of Pittsburgh, and Matrix Research Institute (MRI), a private consulting agency in Philadelphia, were both awarded RSA one year and multi-year training grants in the category "Rehabilitation of the Mentally Ill." As the two organizations' interests in training very much paralleled each other, staff from the RSA Region III office asked both organizations to collaborate in their training endeavors within the region. The experiences of both organizations were founded in two different approaches to psychiatric rehabilitation, one a psychosocial model and the other a clinical-academic-psychiatry model. The two different approaches, instead of conflicting, complemented each other throughout the training program.

Format of the Administrator Level Training Component

Training was conducted with supervisory and administrative staff in addition to direct service staff. Key designated staff from each of the state VR and MH agencies were involved in discussing systems barriers, existing policies, and strategies for initiating and/or implementing a process of interagency collaboration. These state level administrators and managers worked closely within small groups. They were brought together for one or two days at a time over the course of a year to deal with specific areas of mutual difficulty, conflictual issues in need of resolution, or areas where confusion on target populations, goals, or outcome criteria existed.

Collaboration Process Issues: Facilitators and Barriers

In reviewing the work of five of the six states within Region III that participated in the training process, it became clear that many of the interagency collaborative endeavors were remarkably similar. An initial area of agreement concerned the existence of a formal document addressing the nature of an interagency agreement. All of the states that did not have an operational collaborative agreement, that is, one which either agency took seriously, embarked upon establishing a formal written

document. Second, there was a general consensus across the state agencies that many of the tensions between VR and MH would be eased if there were a clear definition of and a way to communicate about (a) reasonable expectations; (b) the way in which MH clients enter the VR system; (c) what a "work ready" client might look like; and (d) when a MH client would be eligible for VR services. The two factors, a formal written agreement and a clear definition of four major client-oriented concerns, served as facilitators to the process initially. From that point on, agreement became disagreement in these early meetings. Six issues emerged, differentiating the systems one from the other. Problem solving had to occur around these if the collaborative process was to succeed.

First, the structure of the agencies themselves had a direct bearing upon the collaborative process. The VR system is a federal-state funded program, hierarchial in structure, and operating on a state level under federal mandates and regulations. The process is a top-down one--from a centralized federal agency to each state, and from each state in turn to its district offices. The MH system, on the other hand, has no central federal regulatory or funding source, but rather operates through state and local level appropriations and regulations. MH programs are independently run by local county MH boards. Thus, instead of a unitary source of authority as in VR, the MH system operates through authority which is dispersed and decentralized.

Second, within the MH and VR systems, perceptions of the clients served were quite different. VR counselors work with a variety of disabling conditions unlike the disability specific concerns of their MH counterparts. MH clinicians, on the other hand, deal with many aspects of their clients' lives (transportation, housing, health benefits, family supports, etc.), not only their vocational needs. The client is seen as a "womb-to-tomb" responsibility for MH workers as opposed to a time-limited one for VR staff, dictated to a large extent by legislative intent (eligibility vs. entitlement services).

Third, the expected outcome of VR and MH interventions differed. For VR, the outcome was specific: successful job placement. For MH clinicians, no one specific outcome was appropriate for all clients. The VR counselors felt accountable on the basis of job placements made; the MH clinicians realized by virtue of contrast, how little accountability was built into their system.

Fourth, the area of appropriate referrals and eligibility determination was a major focus for discussion. This has been commonly described as the "dumping and creaming" process, with VR viewing MH as dumping clients at its door step, and MH feeling that VR creams only the best clients to serve. Neither group was able to articulate adequately the appropriate client for referral to VR and this factor alone allowed for greater understanding of the misunderstanding which occurs around the referral process. Moreover, the issue of "reasonable expectation" as an essential component of the eligibility determination process remained problematic throughout the training period in spite of efforts to deal with the issue through the notion of environmentally specific functional limitations.

The fifth area of concern among the systems involved the type and length of service required by individuals with LTMI and the relationships of these factors to job placement and maintenance services. Both systems were reluctant to admit their lack of success in placing persons with LTMI in competitive employment. VR counselors, by virtue of caseload size, have little time for it; MH clinicians, by virtue of their training, have few skills in approaching employers or helping clients to find jobs. The result is that psychosocial programs and non-traditional rehabilitation agencies take up the slack. Their efforts, however, are often little recognized or poorly financed by the other two systems.

Finally, each system had differing expectations of the other. The concern of the VR agency was to get the MH system to provide more prevocational programming in order to bring the client close to a job-ready phase at which point the VR system would become involved. MH agency personnel desired to expand service options and invest in the process of joint funding for new transitional or supported employment programs as well as sheltered workshop opportunities. Psychosocial agency representatives were primarily concerned with lengthening the time that VR would support a client in training.

Outcomes at the State Level Following Training Experiences in the Collaborative Process

As these joint meetings continued, fostered by grant-funded activities, each state took hold of the collaborative process and proceeded to work out agreements that met individual state needs, taking into account local resources, policy and procedural modifications, and consumer and advocacy input. Within all of the five states, second agreements were written over the course of the four years; but in the case of two

states, where major leadership and organizational structure changes occurred, the implementation of these new agreements has not taken place. See appendix for an outline of the basic components of an interagency agreement, excerpted from the most recent interagency agreement draft from the Commonwealth of Pennsylvania. Copies of operational interagency agreements from several other states are also included.

These continued interagency meetings at the administrative and policy making levels resulted in the appointment of task forces, sometimes at the single agency level and at other times across state agencies and between systems. They were charged with the responsibility of dealing with identified ongoing barriers to the process of interagency collaboration. The identification of problems and recommendations raised a number of critical concerns, emerged from several of these committees. These may provide guidance for other states currently involved in MH/VR interagency agreements. Two of these state task force reports are summarized in the following discussion.

Pennsylvania's Interagency Agreement and Task Force Report

As part of the process of rewriting Pennsylvania's second Interagency Cooperative Agreement, drafted in 1986, a retreat was held to deal with the problems which continue to beset the systems. The Pennsylvania Interagency Task Force, composed of key MH, VR and provider agency personnel, made recommendations regarding the following concerns:

1. Referral and Eligibility Determination. Many counselors still have some difficulty communicating across VR/MH agency lines regarding what type of client with chronic mental illness (CMI) is appropriate for VR services. Some MH counselors are still confused about VR standards of "reasonable expectation" or are concerned about clearly defined standards that are inappropriate for the CMI client population. VR counselors, on the other hand, believe the MH system either does not fully understand VR expectations or disregards them in referring clearly ineligible clients. Definition of terms and design of referral forms with an emphasis on including an early MH counselor estimation of the client's vocational potential, a procedure for VR feedback on reasons for ineligibility decisions, and further

studies of the client/system characteristics associated with Status 26 and Status 28 closures were recommended.

2. Defining and Measuring Progress. VR expressed some concern about the operationalization of VR commitment to continue support for CMI clients who demonstrate rehabilitation "progress." No clarity has yet emerged regarding how much "progress" is enough, and how much time could elapse before VR support would be withdrawn. Further, procedures were not in place to help counselors to measure "progress" over time. The retreat members recommended that VR undertake to define the term and develop a way to measure client improvement that could serve as a standard for both VR and MH counselors.

3. Counselor Communication: Liaisons and Teams. The revised collaborative agreement emphasizes the assignments of VR and MH liaisons to one another and the continued operation of a "VR/MH Team" to engage in joint decision-making with joint clients. There was agreement that these approaches were sound but were being implemented somewhat unevenly. Both VR and MH will acquire the specific names of liaison personnel and ask that special training programs be designed to insure clarity around the liaison responsibilities. It was further recommended that a joint VR/MH directive be sent to supervisory and direct service personnel to encourage increased team decision-making.

4. Interagency Cooperation Monitoring. The group noted the draft agreement's establishment of a standing MH/VR Agreement Coordinating Committee (IACC) and felt that a major function of the IACC should be the monitoring of local (County/District) collaborative activity implementation. There was a strong feeling that some counties/districts would need ongoing encouragement, technical support, and other assistance in order to follow-through on interagency cooperative activities. Early formation of the IACC and discussion of the means for it to monitor on a continuing basis the spirit and substance of local cooperative efforts were recommended.

5. Organizational Incentives. It was recommended that VR explore those incentives that would encourage counselors to work with more CMI clients (e.g., weighted closures, percentage-of-caseload quotas, CMI specialists, etc.) through its performance factors system. MH in like manner should re-examine its allocation

factors in order to reward counties that manage to move more CMI clients into VR programming. The retreat recommended that both VR and MH explore the development of incentives as a priority task.

The Maryland Task Force Report

In June, 1986, the Maryland Assistant State Superintendent of VR appointed a planning group to address unmet needs in the delivery of VR services to individuals handicapped by CMI. The group's charge was to recommend strategies and program changes that would strengthen services and improve vocational outcomes for this population. The initiative derived from a 1985 Division of Vocational Rehabilitation (DVR) planning session which identified improved services for persons with CMI as one of the agency's priority objectives for the years 1986-1988.

The planning group was comprised of representatives from DVR's Central Office, its six Regional offices, the Maryland Rehabilitation Center, Disability Determination Services, and the Client Assistance Program. Representatives of the Mental Health Administration, community rehabilitation programs, and consumer organizations also actively participated.

The group organized its tasks into three broad categories: referral/eligibility issues, program improvements, and interagency/community collaboration. Three subcommittees were established to address issues specific to the three categories. Subcommittees met monthly or more frequently as needed. Those issues assigned a top priority rating by one or more of the three working groups were:

1. Joint training for VR and MH personnel
2. Mutual definition of reasonable expectation
3. Provision of improved pre-vocational services
4. Greater utilization of extended evaluation
5. Further development of vocational programs for the CMI client
6. Development of industry integrated approaches
7. Joint employer education programs
8. Delivery of improved post-employment services
9. Reduced '26' expectations for the CMI client
10. Regular meetings among VR, MH, and Community Rehabilitation Center (CRC) staff

The conclusions of the Maryland Task Force focused on implementing effective interagency collaboration between VR, MH, and community agency systems involved with the provision of rehabilitation services to persons with CMI.

They are based upon the same three factors that were elicited from the direct service staff who participated in training across the states in RSA Region III. They are: the nature of the disability itself (items C, G); intra-agency issues (items D, E, and F); and interagency differences and expectations (items A, B, F, H, and I). The specific conclusions are as follows:

A. Current procedures do not encourage the referral of clients who are ready to benefit from VR services. Referral sources are not sufficiently versed in VR's eligibility criteria to permit them to adequately prepare and assess their CMI clients for entry into the VR system. In addition, prospective clients and their families have unclear expectations of what VR may be able to offer them.

B. An established, ongoing community support network consisting of the client, appropriate members of the client's treatment team, and family members, needs to be in regular contact with the VR counselor throughout the VR process.

C. The success of the initial interview and the frequency of counselor/client interaction during the period of evaluation for rehabilitation potential appear to have significant impact on final outcomes. VR counselors need to be skilled in interview/counseling techniques appropriate for the CMI population.

D. Appropriate evaluation of rehabilitation needs and potential requires a comprehensive evaluation that relies upon work experience and observations of work behaviors in actual job settings provided via opportunities such as supported employment or transitional employment. The ratings of work adjustment skills provided through workshop settings are next in order of preference for evaluation.

E. A specialized service delivery model is necessary to effectively meet the unique needs of this population. Ideally, this would be accomplished by establishing specialty counselors working exclusively with CMI individuals. A more immediate and perhaps practical approach would be to improve and streamline the service delivery model, using existing staff. This can be accomplished by emphasis on two major issues: uniform good practice standards and staff training.

F. Traditional vocational training programs are not uniformly appropriate for individuals with CMI. Supported employment, with emphasis on employer education and long-term follow up, appears to be a more effective vocational strategy for this population.

G. Many concerns and hesitations harbored by field counselors, in terms of working with clients, are based upon lack of knowledge of the population and of the most effective means of working with those with severe psychiatric problems. The VR Agency needs to take a more active role in providing counselors with the knowledge, skills, and resources to do a better job with these clients.

H. The existing cooperative agreement between VR and the Department of Health and Mental Hygiene has not actively promoted vocational outcomes for those with CMI. Since the discontinuance of VR units within state hospitals, vocational goals for the CMI have been less clearly defined. Likewise, the vocational goals of the psychosocial or CRCs remain unclear, especially in light of increased dependence of CRCs upon Medicaid funding. Although CRCs have been certified by VR as work adjustment training sites, very little in the area of competitive employment placement and retention has resulted.

I. There is insufficient collaboration between VR staff and MH consumers at both primary and secondary levels with respect to policy development and service delivery issues.

(Maryland Task Force Report, 1987).

IMPLICATIONS: What, then, are some of the principles that can be extracted from the training experiences with these interagency administrative and supervisory staff? Which principles parallel those factors identified in the literature as critical to the process of interagency collaboration? Furthermore, which principles, in particular, can be identified as facilitating interagency collaboration among VR, MH, and provider agencies in working with a client population with LTMI? A summary of the principles that emerged over the course of the training activity previously described follows:

1. Individual factors can be either barriers or facilitators.

2. Long-term commitment of key leadership personnel is required.

3. Involvement of front line staff must occur at the earliest stages.

4. The establishment of sufficient, formal written agreements is necessary.

5. Ongoing joint training programs are essential to the collaborative process.

6. Mutual trust between agencies underlies the entire process.

7. Readiness for consumer involvement must evolve.

First of all, in accord with the writings of Broskowski et al. (1982), individual factors, no matter how critical to the process, can be either barriers or facilitators. If there is a change of leadership in the midst of ongoing efforts at collaboration, the whole process can, and often does, fall apart. This occurred in one state in which training in collaboration took place. Leadership in another state was the key to allowing the collaborative process to move off dead center.

Second, it appears that there must be commitment to the process over the long-term. Interagency collaboration is not a one-time activity that is accomplished once an interagency agreement is written and the parties agree to work together. When problems arise in the implementation phases, as they most surely will, top administrators in both systems must be committed to the resolution of conflicts and the removal of potential barriers.

Third, front-line staff must be involved in the process from the beginning. These are the folks who have to carry out the agreement. Unless there is some kind of representation of front-line staff in the planning as well as implementation phases of interagency collaborative efforts, written agreements, no matter how formal and detailed, will not be actualized.

Fourth, all of the agency representatives involved in the training program spoke to the necessity of having a formal written interagency agreement. None of them were comfortable with having a "gentleman's agreement." They all felt that, before anything substantive could take place, there had to be a written agreement wherein the parties involved went out on the line and said, "this is

what we're willing to do." Elder and Magrab (1980) dealt with the same issue when they described the factors which inhibited interagency collaboration in the field of special education. Among these factors were the following salient points:

1. The spirit of cooperation must be supplemented with the concepts and procedures necessary to overcome the many governance, organizational, and functional barriers that characterize all levels of bureaucracy.

2. A properly designed interagency agreement reflects the constraints, requirements, and discretionary authority of each participating agency.

3. The design of a successful agreement is based on an analysis of common purposes across agencies and acceptable options for meeting those responsibilities through cooperative efforts.

Fifth, there have to be opportunities and support for training, particularly joint training. Further, training is not a one time event. Staff turn-over, staff reassignments, new technologies, and research in both systems require an updating of the knowledge and skills of front-line staff. This principle parallels one of the original initiatives established in the 1978 NIMH-RSA cooperative agreement.

The last two principles support all of the five principles outlined above. The first of these relates to the issue of trust (Dellario, 1985). It is imperative that cross-system agencies have a basic level of trust in each other. Each must hold up its share of the bargain regardless of which agency takes the lead role. In some states the VR agency took the lead role in this process. Their MH counterparts had to trust that the VR agency was acting in the best interest of both parties. In other states the MH agency took the lead role and the VR agency had to say in an implicit way, "we trust that what you have proposed will facilitate the delivery of appropriate services to our mutual clients."

The final principle is concerned with consumer involvement in the collaborative process. Observations of the training experience led to the conclusion that only when basic concerns, conflicts, and procedures are worked out between agencies does a kind of security bond exist between them that enables them to be open to consumer involvement. In those states where cross-agency staff worked together over a period of time, formal mechanisms

were established to involve consumer groups in the ongoing process. In addition to reliance on informal networking with highly visible advocacy groups, a concerted effort was directed at reaching representative consumers and their families at the local community level. It was clear that a commitment should be made to include consumers in committees to monitor the consumer-oriented actions of the collaborative process over time. Finally, a long-term commitment on the part of administrators would be needed to support efforts that would facilitate meaningful, ongoing consumer involvement in the collaborative process.

SUMMARY: In conclusion, whether or not the process of interagency collaboration has a meaningful, measurable, and substantial impact upon the rehabilitation of persons with LTMI has yet to be empirically demonstrated. However, demonstration of its validity and effectiveness may not be far off given the recent impetus to interagency collaboration via the supported employment movement. The supported employment model requires interagency collaboration and cooperation on a variety of levels--planning, personnel, fiscal resources, core services, long-term management and funding. By and large, these issues have not been resolved beyond the parameters of particular demonstration grants and current available funding. Once these demonstration project monies and special set-aside funds are no longer available, community organizations and agencies will be faced with the issues of long-term funding and management. In order to achieve client-oriented outcome measures, and to validate the cost-effectiveness of these supported employment initiatives, the cooperation and collaboration of multi-system agencies and programs will be essential. It is hoped that the preceding discussion drawn from the experiences of special educators, MH professionals, and training specialists in the interagency collaborative process will prove helpful to administrators faced with this ongoing responsibility.

Chapter 4

Approaches and Models of Service Delivery

INTRODUCTION:

Although cooperative relationships between MH and VR agencies have been complicated, requiring a great deal of study and effort, progress has been made in delivering comprehensive services to persons with LTMI. This chapter highlights only a few. The assertive case management approach developed by Stein and Text (1980) and a summary of the psychosocial rehabilitation approach have been omitted because there is ample literature on both approaches. Interested readers are encouraged to discover the availability of these models in their areas.

Much of the available psychosocial rehabilitation literature fails to distinguish between psychosocial rehabilitation literature in general and the Clubhouse Model; thus a section on the Clubhouse is included. A section of this chapter describes the group transition model of George Fairweather which has resurged recently, primarily in Texas and Michigan. The supported employment initiative has had an impact across the nation. Unfortunately, the special needs of persons disabled by persistent and long-term mental illness in contrast to those of persons with other developmental disabilities have, in many cases, been ignored. A section on supported employment for persons with LTMI is, therefore, included. Finally, a section on the Boston University Psychiatric VR Model is presented.

SELECTED APPROACHES:

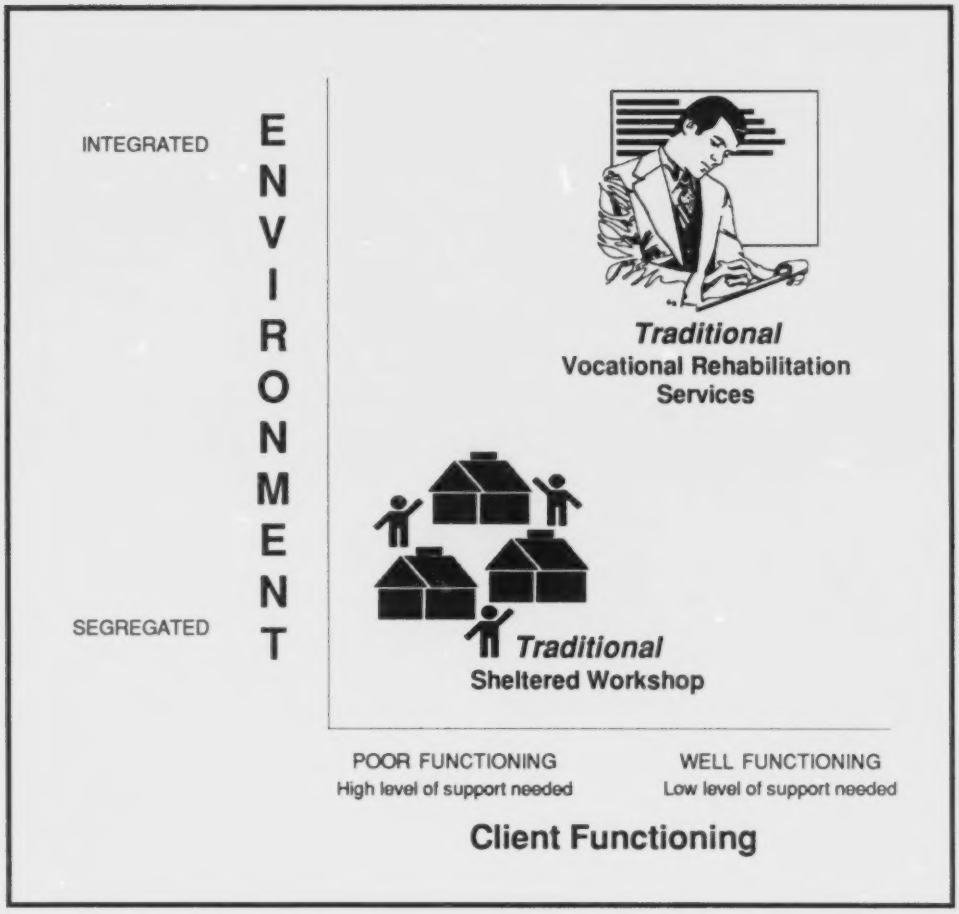
The ultimate objective of VR for persons with LTMI is the highest level of independence with the fewest restrictions possible. However, a wide variety of opinions about how this goal can best be achieved exists within the field. Furthermore, resources, service delivery systems, and opportunities vary according to funding resources, demographics, and philosophies.

Some service providers, while working with persons with LTMI, propose a continuum of services whereby a consumer learns increasingly complex skills, and thus moves on to more independent settings, and ultimately, employment. Others advocate a milieu based upon each person's individual needs and designed to accommodate the individual at any point in the rehabilitation process. With this system, progression from one level of a program or one phase of a program is unnecessary.

As the Institute on Rehabilitation Issues Prime Study Group struggled with the broad range of facility/service models available, a descriptive format unfolded. The members of the Study Group began to design a diagram that would describe services as they related to the level of employment environment ranging from very protected (the

sheltered workshop) to full competitive employment in the community without agency support. This range of environments has been placed on the vertical axis in Figure 5. Likewise, the study group described consumers in terms of their current level of functioning. Those needing the most support were identified at the left of the horizontal axis, while those who needed little or no support were placed at the right of the horizontal axis.

Figure 5



The diagram then served as a framework to discuss a variety of service options for persons with LTMI. An attempt was made to place services in an appropriate place on the diagram. This proved to be a very difficult task. Some members of the study group felt that certain services, such as sheltered workshops, were outmoded and inappropriate and should not even be included in a discussion of approaches used to serve this population.

Other service delivery models were presented which, by their very nature, were designed to include all types of environments and all levels of support. The diagram, then, should be used only as a reference point, a point of discussion, a basis for comparison of services because the need for services changes over time. New consumer populations are identified and funding changes, as does the technology of VR.

Descriptions of the selected approaches address the following aspects of the "typical" VR process:

- assessment
- planning
- vocational training/preparation
- job placement
- follow-along

The Prime Study Group decided to describe briefly a few of the typical approaches presently being used. These are just some of the approaches that have been found to work with some consumers in some settings. The challenge for service providers, or others who want to develop new services, is to evaluate existing resources and adapt some of the services presented, or to create an entirely new service.

CLUBHOUSE MODEL:

The Clubhouse Model is difficult to describe. Written reports of the philosophy have failed to communicate the essential experience of a clubhouse. The interested reader is urged to follow-up this reading with a visit to a bonafide clubhouse program in order to gain personal experience and understanding.

The Clubhouse Model is the Fountain House model; and, to this day, Fountain House remains at the forefront of the clubhouse movement. The clubhouse is a psychiatric rehabilitation intervention that is part of the broader psychosocial rehabilitation movement. Yet the clubhouse is clearly separate from the rest of the pack. It cannot be explained by describing a particular structure, program or organizational system. Rather, the clubhouse is best understood when it is perceived as a culture and experienced through individual journey and discovery. (Participants tend to talk about their "world.") For those outside, the "world" is almost incomprehensible. Some writers have presented an isolated pocket of the clubhouse; but, like the blind man with the elephant, they miss the point.

What the Clubhouse is Not

The clubhouse is not time-limited. Participants may use and contribute to the clubhouse indefinitely. (Participants are referred to as members because "membership" more accurately reflects the roles they play.) Traditional rehabilitation planning is time-fixed.

The clubhouse is not unidirectional. In traditional rehabilitation, the client receives services from the staff. In the clubhouse model, however, it is often difficult to distinguish between member and staff because many of the roles are similar. Clubhouse staff do not see themselves providing services to clients. They see themselves working along with the members to achieve the day's objectives.

Traditional rehabilitation efforts are essentially disability based. The client's disability forms the central locus around which treatments are planned. Conversely, the clubhouse is not disability based. The needs of the clubhouse form the locus from which members' abilities are drawn. The difference is striking.

As Vorspan (The Fountain House Annual, Vol. 4, December 1986, p. 57) notes:

> The allure of membership in the clubhouse is the polar opposite to the allure of the traditional MH institution. Fountain House members and staff come to the club every day because they are immersed in a world of appreciation, of normalcy, of the reflected beauty of other's newly discovered talents and strengths. They do not come, as members, to find a safe retreat from autonomy, where they can snuggle comfortably (or painfully) under the quilt of their craziness.

The clubhouse is not tracked, and individual members will experience it differently. While traditional interventions seek to protect clients from failure, the clubhouse philosophy posits that there is no success without the opportunity to fail. Although the clubhouse culture supports and protects carefully, there are no set steps or prerequisites to follow. Going to work is a right of clubhouse membership that is not predicated on successful completion of steps. Therefore, the route to employment (a status highly valued in the club culture) is nonlinear and non-departmentalized.

The clubhouse is not, however, a place where anything goes. The best representatives of the clubhouse model

follow closely the tenets and values of the clubhouse philosophy. Newly developed techniques may become part of the clubhouse only if they "fit" into the culture. The clubhouse schedules no individual or group therapy, no activities of daily living classes, or psychodrama, and no in-house sheltered employment. These and other activities are seen not as harmful but only as inappropriate in the clubhouse. They are incompatible with the member-staff relationship, which is the heart of the clubhouse model.

What a Clubhouse Is

Real work opportunities must be an integral part of the milieu in a clubhouse. By far the most successful of these is Transitional Employment (TE). A clubhouse without TE is not really a clubhouse at all. Supported Employment (SE) is also being used by clubhouses with considerable success. TE and SE provide clubhouses better access to the resources of state VR agencies.

Transitional and Supported Employment

Considerable debate has arisen concerning similarities or differences between TE and SE. The clubhouse community interprets any differences as procedural rather than fundamental. While the "typical" SE client may work for and sustain employment with a single employer, the typical TE client will be employed for the same amount of time but for different employers. Further, while most TE slots are part-time, so are many SE slots. Although a "full-time, permanent" SE slot appears dissimilar to a "part-time, transitional" one, the structure which enables each is the same. Both embody on-the-job and around-the-job supports, and both presume a relationship system that links the members, the staff and the organization. Thus, from the perspective of the clubhouse, the TE program and the availability of VR funds for SE provide a unique opportunity for clubhouses and VR agencies to work more closely together.

Transitional employment is designed to circumvent barriers that prevent psychiatric patients from working in commerce and industry. The primary purpose of TE is to strengthen basic work habits, motivation and attitudes necessary to all jobs.

By bypassing TE barriers, members are able to realistically test their capacity to perform productively on a real job. The clubhouse staff and membership are able to evaluate in concrete terms whether a member can get along with co-workers and bosses, be punctual, and have a good attendance record on the job. All of the factors that

enter into success on a real job become highly visible. In addition, the TE program provides members with a current job reference and, most importantly, restored confidence in their ability to work on a real job. LTMI participants are considered employees and are paid by their companies rather than through the clubhouse program. This makes a great deal of difference in how the members see themselves, and the kind of references they establish.

The primary characteristics of TE programs are:

1. All placements are located in normal places of business, ranging from large, nationally recognized corporations to small local firms employing only a few individuals.

2. TE placements are essentially entry level requiring minimal training or job skills. The prevailing wage rate is provided by all employers for each job position, ranging from the minimum wage to over $6 an hour with a few positions paying over $8 an hour.

3. Almost all jobs are worked on a half-time basis so that one full-time job can serve two members at a time. This allows each member to be at the clubhouse half the day. Many programs provide weekly or bi-weekly dinner meetings for TE members to get together for mutual support and celebration.

4. Although the member works in the presence of other employees, most TE positions are individually based. Some placements, however, are performed on a group basis where six to ten members work together. All placements "transitional" in design, providing employment for approximately 6 months in duration. TE is designed to enable members to go to work for as little as a few hours a week to 20-25 hours per week. Although each placement is time limited, employment is not, as members will often move from one placement to another without interruption.

5. TE provides a guaranteed opportunity to work. TE is considered a right of membership not a privilege. Members maintain their placements only if the employer's work requirements are met, and employers do not adjust or lower standards. Job failures are viewed as experiences which the vocationally disabled member must, in most instances, undergo to eventually achieve a successful work adjustment. In the work experiences of non-disabled individuals, failure or withdrawal

from entry level employment often occurs also. TE employers emphasize that job turnover rates are not typically greater for LTMI club members than they are for their non-disabled employees.

The Clubhouse and Housing

The mature clubhouse also incorporates housing and housing support services and operates seven days per week. Many varieties of housing services are offered by the clubhouses. Scattered site apartments are popular with clubhouses because they are inexpensive, less staff intensive and more "normalized." Generally, the clubhouse will rent and furnish an apartment and then sub-let it to two or more members. The residents share the expenses of food, rent and utilities. Day program staff provide supervision as needed. Independence Center, a St. Louis clubhouse program, operates a hybrid apartment program. The Center renovated a building with 19 efficiency units that houses 19 members. Each apartment has its own kitchen, but there is a large common kitchen and other common areas that all residents may share. No staff live in the building and supervision is accomplished primarily by the residents themselves with weekly staff visits.

Some clubhouses also offer supervised congregate living opportunities in addition to scattered site apartments along with a full range of housing support options. In general, clubhouses offer housing to club members only and do not accept non-members directly into housing. The club is available to all members several evenings per week and all holidays. As with employment, these services are provided as an integral part of a complete program and line staff are involved in all program components. With few exceptions, the clubhouse has a staff of generalists who participate in employment, housing, evening, weekend, and holiday program services.

The Clubhouse and Case Management

The members and staff of the clubhouse perform case management functions. The clubhouse encourages each individual to be his or her own case manager, but assists as necessary. There is a daily out-reach function to members who do not attend. Members and staff help members obtain services from physicians, dentists, lawyers and other professionals. A clubhouse at its best never lets a member forget that he or she is valued, wanted and needed. Many case management functions are logical extensions of these concepts. Thus, if a member is in pain or crisis, it is right and appropriate that the clubhouse

community gather around the individual and give sustenance and care. Caring may mean helping to obtain hospitalization, therapy, antibiotics, shoes or a warm winter coat.

The key to clubhouse case management is mutual help. When members understand that they have the capacity to be helpful, to powerfully affect another member's life, they gain a sense of wholeness and independence that is the goal of rehabilitation. This is a contagious process that influences both members and staff by changing the attitudes and expectations of both groups. Mutual help also differentiates the clubhouse from other movements which tend to isolate "consumers" from "staff." Clubhouse case management empowers both consumers and staff in service to the individual.

In summary, the clubhouse provides a broad base of community and personal support and opportunities. Like a healthy family, the clubhouse is concerned with all aspects of its members' lives; it nurtures and supports indefinitely and acknowledges the achievement of independence without "closing the case." State VR counselors may use clubhouse programs to provide carefully delimited services (such as SE/TE, Work Evaluations or Work Adjustment Training) and the counselor can be further assured that even after the VR case is closed, the clubhouse family is available to support in times of crisis and celebrate in times of joy.

SUPPORTED EMPLOYMENT APPROACH:

The sheltered workshop was one of the first approaches to providing vocational services for persons with LTMI. In theory, after the individual consumers completed a training period within the workshop, they would be referred to a VR counselor for placement in competitive employment. However, a number of problems surfaced regarding this continuum of services, particularly for persons with severe disabilities. Consumers stagnate at different levels, more often because of inadequate training methods and lack of staff rather than any lack of work skills. In some cases the workshop simply needed to keep the best workers in order to meet production schedules and quotas.

The SE approach was developed as a response to the inadequacy of service delivery systems for achieving competitive (i.e., train and place) employment for persons with severe handicaps. Initially developed as a service model for persons with developmental disabilities, the goal of SE is competitive employment in integrated settings, with whatever degree of ongoing

support (training, supervision, transportation, case management, etc.) is required. Danley and Melien (1987) have identified factors that distinguish the implementation of the SE approach for persons with psychiatric disabilities. Although the basic philosophy of the SE approach to LTMI is the same as the approach to other types of disabilities, the technology of implementation should be adapted to the particular strengths, interests, goals and abilities of the individual with LTMI.

ENCLAVES, MOBILE WORK CREWS, AND THE ENTREPRENEURIAL

The SE approach sometimes includes mobile work crews, enclaves, and entrepreneurial efforts. As an example, Thresholds in Chicago has created a sheltered workshop which operates within a factory. It affords the advantages of a sheltered workshop while eliminating many of the disadvantages. The consumers are integrated into the non-disabled work force, but piece rates are maintained under a Department of Labor certificate. This permits even the most limited consumers to function as factory employees. A similar enclave is located within an electronics company where up to eight individuals with severe mental disabilities perform on-line duties with supervision by a specially trained foreman. A nonprofit organization funded by a state agency provides support to the consumers and the electronics company. Wages paid to the enclave workers are commensurate with pay to others within the company who perform the same amount and type of work. Consumers also receive the same benefits as other employees. Limited work abilities and behavioral needs of the consumers, however, may require that they be situated in close proximity to one another to enhance training and supervision.

Vocational assessment in the enclave becomes meaningful because the nature of the placement closely approximates real working conditions. The consumer is exposed to other options, possible career moves, and is better able to do vocational planning.

Mobile work crews, particularly in the service sector, provide many of the advantages of the integrated employment setting with the support of a trained crew supervisor. To qualify as a type of SE, the work crew employees must be paid wages commensurate with their production. The TE component of many Psychosocial Rehabilitation Programs often includes mobile work crews which do meaningful work for the operation of the agency, or other nonprofit agencies (Bond, 1987). The focus of such work crews is on teaching necessary skills and work habits prior to moving on to other TE. The Javits-Wagner-O'Day Program has provided employment opportunities for

persons with LTMI on mobile crews doing janitorial and custodial work, lawn maintenance, commissary shelf stocking, and similar work. Many "traditional" sheltered workshops have operated mobile work crews in integrated settings for a number of years. Very often such employment provides an opportunity for consumers/workers to assess their own interest in continuing to work in that type of occupation and at the same time to demonstrate work skills, stability, attendance, and interpersonal skills to potential employers.

An extension of enclaves and work crews has led many private organizations into entrepreneurial efforts. Such efforts offer a variety of opportunities often not found in traditional sheltered workshops, mobile crews, or enclaves. Some facilities have opened franchise donut shops and other bakery shops staffed by severely disabled individuals. Others have opened catering businesses, wholesale grocery supply operations, restaurants, etc. The list is literally endless, and the significance is that most of these provide employment in integrated settings dealing with the public. The work is meaningful, pay is commensurate, skills are being learned, and the support can be adapted to the individual.

Several other distinct advantages are gained when the facility serves as entrepreneur. First, there is a natural opportunity to assess job and independent living skills as the person performs in the community. Second, planning becomes a matter of choice based on experience on the job rather than in the classroom of some facility. Development of skills and placement is built into the system. In fact, Thresholds in Chicago has developed the natural extension of the facility as entrepreneur. Thresholds is beginning a program to teach persons with LTMI the skills necessary to own their own businesses as a spin-off of the agency business. Janitorial contracts are well suited to an entrepreneur with relatively little capital becoming a supervisor and eventually an independent business owner. "Workforce 2000," a recent report prepared for the Department of Labor by the Hudson Institute, predicted that the service industry will create most of the new jobs through the year 2000.

JOB COACH: The job coach works directly with the client and the employer. This professional is often responsible for obtaining an agreement from an employer to hire an individual at competitive wages. Some SE programs have a separate staff member who will develop employment opportunities for a large number of persons, while job coaches may work full-time with one or more persons on the job.

Once a potential work site is identified, the process of matching the client and job according to the aptitudes, interests, desires and goals of the consumer begins. Too, professionals in the field indicate that client choice and participation in selecting vocational goals is an essential ingredient in the rehabilitation process for persons with LTMI.

Once the "match" has been made, job coaches teach the job skills required, and even perform the duties themselves if production quotas are not met. This "guarantee" often reduces the fear many employers have regarding employment of persons with LTMI. The job coach must assess both employer and employee needs, develop strategies to provide help and support when needed, and also allow for freedom, self-direction, and independent functioning when required. The job coach, in addition to arranging for job accommodations, may deal with financial disincentives, transportation, counseling, and various other duties. The length of time a job coach may need to work with one employee is indeterminate because of the nature of LTMI. Yet the job coach cannot continue to work with a single individual indefinitely since programs are pressured by funding sources to work with groups of clients. The problem of how and when to reduce intensive on-site support has been identified, but more research is needed with this population to arrive at a conclusion.

Although follow-up services are essential, they may need to be accomplished after working hours in order not to call attention to the worker (Anthony & Blanch, 1987).

Demands placed upon the job coach are high, and schedules are long and unpredictable. Job coaches need the knowledge, attitude, and skill competencies to work with both client and employer.

TRADITIONAL VOCATIONAL REHABILITATION AND GROUP TRANSITION:

Amendments to the Vocational Rehabilitation Act of 1973 have expanded to encompass persons with mental disabilities as target population for VR services. Legislation has authorized the development of community MH centers and implemented deinstitutionalization of patients from mental hospitals.

Traditional VR evaluated the disability and how it could be alleviated or significantly reduced so that the individual could be gainfully employed. However, most VR services were initially designed for "tangible" handicaps, usually associated with physical disabilities and

mental retardation, which do not alter or fluctuate as much with the influence of outside variables as does LTMI. But, it is crucial to be aware that the daily life of a person with LTMI is one of continual change.

Federal regulations (Public Law 93-112, p. 6) require that eligibility shall be based upon:

1. The presence of a physical or mental disability which for the individual constitutes or results in a substantial handicap to employment

2. A reasonable expectation that VR services may benefit the individual in terms of employment.

Establishing the disability for a mental disorder is a relatively simple step. This can be done by obtaining hospital records, out-patient treatment records, or if necessary, by having the client assessed by a current psychological evaluation. As with any disability, the medical information is meant to ascertain the functional limitations, duration and prognosis of the disabilities. The diagnostic process also includes vocational, educational, current general physical examination, and other related factors which depend on the individual's handicap as related to employment and rehabilitation needs. The thorough diagnostic study appraises the individual's personality, intelligence level, educational achievements, work experience, personal, vocational and social adjustment, employment opportunities, economic situation, attitude toward work and other pertinent data to establish the severity level of the disability, and to consider the feasibility issue for determining the nature and scope of services needed.

Until recent years, many people with mental disorders were considered too severe and/or not feasible for VR services. Fortunately, however, mental disabilities are not assessed by mental history and current functioning of the individual. They are classified by the diagnosis (psychotic, neurotic, and personality disorders) ranging from non-severe to most severe (Appendix B). Given these classifications of severity, most individuals with LTMI who demonstrate an attempt to participate in a vocational plan, can be considered feasible. Success will depend on accurate assessment of the current functioning level, utilization of community resources, joint planning with MH professionals, and the availability of employment options.

Vocational services previously emphasized restoration and training (i.e., academic, vocational/ technical and on-the-job) in order for an individual to enter the job market. If vocational programs are not available to people with severe mental disabilities who have had long-term, and multiple hospitalizations with multiaxis diagnoses and dual disabilities, then VR agencies alone cannot successfully rehabilitate the LTMI population. The need for different modes of employment rather than the more general structure of employment was also recognized. Intra-agency involvement, community resources, and an array of employment models can alleviate and/or significantly reduce the symptoms of an individual's LTMI to help him or her function in the community setting.

In addition to the normal array of services available to all VR clients, group transitional programs evolved for MH clients. Most significantly, these offered residential placement along with an opportunity to become self-supporting.

One successful model from which many transitional programs have been adapted is the Fairweather Lodge, originated by George Fairweather at a veterans' hospital in California in the 1960s.

The Fairweather Lodge Program, which originates in state hospitals, is a unique program for persons with severe LTMI. The goal of the program is a cohesive group of chronic, ex-mental patients, living together in the community, supervising themselves, solving their living problems and operating a group-owned business which provides a means of support for a community home referred to as a "lodge."

A professional team comprised of hospital staff, VR counselor, and community MH personnel assists in the selection of patients appropriate for Fairweather Lodge Programs. Although these patients may adjust in the hospital environment, they demonstrate limited capacity to adjust socially and vocationally outside of a protected environment. Selection is generally based on a client's inability to work in the competitive labor market and to live in the community without a supportive living situation. Frequently, the family constellation is an unhealthy environment and is not conducive to the well being of the individual.

Phase I of the lodge model is a Hospital-Based, Transitional Living Unit which prepares the group of chronic patients for community living. Here for up to

twelve months clients are taught daily living skills, work skills, communication skills and acceptable behavior patterns. This phase encourages the clients to take increasing responsibility for their own lives, to make decisions and to solve problems. During this time, they strive to become self-medicating and self-governing by learning about their illness and the need for and effects of medication.

Phase II is a community-based lodge which provides a structured setting for living, employment and peer support. This lodge becomes the patients' home for as long as they may desire. It offers a supportive group-living situation emphasizing autonomy and self-government. The lodge members are employed as a group with contracts for work such as janitorial services or grounds keeping. The lodge may elect that some members, instead of fulfilling business contracts, may perform other duties as cook and housekeeper for the residence.

Some lodge models allow for replacement members to come individually from the Phase I of the hospital program or from community agencies. Existing lodge members have varying degrees of control over the acceptance of new members, but are usually willing to give new persons a trial to determine if they fit with the group and the goals of the lodge.

The acceptance of replacement members from resources other than the hospital also helps to meet the needs of this population and the community. Often new residents come from the "street" or from temporary shelters such as the Salvation Army. Again, new lodge concepts have derived from the original Fairweather design. Movement is toward community training lodges rather than the hospital phase.

The local state/county mental health agency or a non-profit agency provides staff members to work as lodge coordinators. They may provide guidance for members with transportation needs, out-patient clinic appointments, self-administered medication, etc. They may also help with rental of the residential facility, location of contract employment, and with intervention as needed or requested by members. With some programs, this agency also manages the business and administers employment contracts for the lodge.

Members are responsible for their own residence. Lodges do not have live-in staff and the members make all of the decisions regarding their work and living situation. The

lodge coordinator's primary role is to act as a consultant to the lodge and not to become involved in the every day life of the lodge. Lodge members are informed from the beginning that there are certain key criteria that they must accept if they are to be at Fairweather Lodge. These have to do with work, rules within the lodge, and medication management.

VR services provide start up funding for each new lodge. This is usually in the form of room and board, work adjustment training funds, and tools and equipment for contract employment. Again, this varies from state to state and with different program models. The vocational counselor can be a valuable resource to the members in helping with job leads and providing client equipment. The counselor also works closely with other professionals, maintaining a net-work of support systems for the lodge's goal of community independence.

A lodge member may at any time request further services from VR. While still a lodge resident, a member may desire more traditional services of academic, vocational/technical training or help with job placement for a vocational goal other than the contract employment. These services may be provided if the individual is functioning at a level appropriate for the desired vocation and if the other group members agree that responsibilities to the lodge will be maintained. Ex-lodge members living independently in the community may at any time request further services from VR; but, again, eligibility requirements must be met, functioning level established, and realistic goals determined. These MH clients must demonstrate stability during the interim in order to receive traditional vocational services.

Another existing program is the Apartment Program. The apartment model conducts joint screening of clients along with Fairweather at the state hospital. Those selected participate in the transitional living unit for a short period of time (one to three months) to prepare them for discharge. These individuals are also severely handicapped, but are able to live independently without the need for group residence or group employment. Most often, these clients have some history of employment and have been compliant with an aftercare treatment program. The apartments are located at various complexes throughout the city. They are leased and overseen by the local MH agency. Each apartment is assigned an apartment coordinator who oversees the residents and intervenes as needed. The apartments are usually two-bedroom, two-bath, with four people to an apartment. Appropriate

behaviors and social skills are important since there are three roommates to get along with.

Apartment residents are required to be compliant with aftercare and to be active. A MH clubhouse offers the residents both social and vocational services. The social component offers free tickets for community functions and planned outings.

A VR counselor works jointly with the MH case manager to provide an array of services: work orientation class, vocational evaluations and unpaid work units at the house such as clerical, cafeteria, janitorial, and grounds keeping so that members may refresh their skills and develop work tolerance. There are also paid litter crew contracts that provide the opportunity to observe work habits prior to placement. Job clubs assist with resume' preparation and application completion and help to conduct the job search. In addition to traditional VR services, maintenance, transportation, and help with the living arrangement may be provided. Not all members will require these services. Some are able to access the competitive job market quickly, but all participate in planning their own services which are based on individual need and the IWRP.

Although persons with LTMI may require guidance in developing a realistic framework for their rehabilitation, they, like non-disabled persons are entitled to freedom of choice. They, too, have the right to succeed or fail by their own efforts.

A PSYCHIATRIC VOCATIONAL REHABILITATION APPROACH:

During the last decade, a psychiatric approach to VR has been developed by staff from the Center for Psychiatric Rehabilitation at Boston University. This approach synthesizes the elements of certain psychotherapeutic and traditional physical rehabilitation practices found to be effective with psychiatrically disabled persons (Anthony, 1979; Anthony, Cohen, and Cohen, 1983; Anthony, Cohen, and Farkas, 1982). Called the psychiatric VR approach, it presumes the legitimacy of work as an out-come and dictates provision of the types of interventions required to assist persons with psychiatric disabilities to be successful and satisfied in environments of their choice (Danley, 1984). Choice of the term "approach" rather than "model" was purposeful because the inherent strategies can be practiced in a variety of rehabilitation settings and adapted for use with a wide range of persons who have psychiatric disabilities.

Research indicates that the primary predictors of vocational success are the person's functional skills and the availability of environmental supports (Anthony & Jansen, 1984). Therefore, preferred rehabilitation interventions are those that develop skills in the person and resources in the person's world.

The major components of a VR program utilizing this psychiatric rehabilitation approach have been described and defined (Anthony, Cohen & Danley, 1988). They include 1) the program mission, 2) the program structure, and 3) the network of environments in which the program operates.

The Program Mission

The mission statement of the program establishes the direction for program development and operation. Without a clear rehabilitation mission statement, programs often lose their focus and become variations of therapeutic programs whose mission is to cure, or custodial programs, designed to protect and insulate clients from activities which may, because of the presence of stressors, precipitate symptomatology. In contrast, the mission of a VR program is "to increase a person's ability to function as independently as possible in the work environment of that person's choice" (Anthony, Cohen & Danley, 1988).

The four key concepts inherent in the mission statement are functioning, choice, environmental specificity, and independence. Functioning as a key mission concept directs the focus of the program's activities toward the development of the clients' work-related competencies rather than toward the reduction of symptomatology. The concept of choice implies active participation by the client in the selection of the preferred work activity and setting. Environmental specificity demands that program activities include those that result in placement, that is, the mutual selection of and attainment of admission to the particular environment that matches the client's values, skills and needs. The concept of independence dictates the gradual weaning of the client from agency support by providing interventions which increase the client's skills and natural supports.

The Program Structure

The structure of an effective VR program must incorporate practices emerging from the knowledge available in the conceptual and research literature. It must also reflect the concepts inherent in a rehabilitation mission. The following statements represent desirable program ingredients which reflect an understanding of current

psychiatric rehabilitation knowledge, based on the findings of the Prime Study Group.

I. Effective Vocational Rehabilitation is Done With, Not To or For, the Person with Psychiatric Disability

Practitioners consistently report that motivation is a major problem in providing VR services to persons with psychiatric disability. Lack of motivation, while to some degree an attendant condition of the illness and the treatment, is also a function of having habitually experienced oneself as someone whose needs must be externally met. Often, these persons have learned that in order to get well, they must comply. They must first agree with the diagnosis ascribed to them by someone more knowledgeable than themselves; then, they must submit to a plan for treatment into which they have had little or no input; finally, they must adhere to a treatment regime which, in and of itself, may produce debilitating side effects.

Following what may have been years of this experience, it is often extremely difficult to generate a personal viewpoint of or enthusiasm for new directions. Yet, if VR is to result in a positive outcome, it is necessary for the client to want it to occur, particularly since rehabilitation interventions often require unsettling changes in the client's behavior and environment. It is critical, then, that the client be fully engaged as a partner in every phase of the rehabilitation process. Cursory cooperation with a rehabilitation practitioner is not enough. The client must be invested in the vocational goal, the rehabilitation plan, and in full participation in the rehabilitation interventions. When the vocational goal is selected with little or no client input, the client often complies outwardly with the VR activities while inwardly experiencing resistance which presents itself as passivity or, at times, deliberate refusal to continue to participate in the rehabilitation process.

II. Effective Vocational Programming Acknowledges Each Client's Unique Values and Personal Strengths

Rehabilitation as a field is anchored on the assumption of residual capacity. That is, an impairment, while limiting the overall ability of the client, can be compensated for by enhancing existing strengths and developing new ones (Anthony, 1979). Although

psychiatric illness disrupts a person's life dramatically, destruction is not total. Psychiatrically disabled persons still maintain inherent abilities and the potential to develop many new ones. There is little evidence that psychiatric dysfunctions are correlated with a client's functional skill level or learning capacity (Anthony & Jansen, 1984), nor is there any evidence to suggest that a person's unique system of vocational values is altered by the advent of a psychiatric disorder. In spite of the presence of a diagnosed psychiatric disorder, the person continues to possess a set of personal preferences and abilities. While they may require review to verify current relevance, these residual capacities of the person remain intact and can serve as the nucleus for new growth and personal development. Thus, it behooves programs to institute activities that enable practitioners and clients to identify vocational values and residual skill strengths, as well as skill deficits and medical limitations. A vocational goal which reflects a comprehensive and balanced picture of the client and the client's perspective will more likely be one in which the client can become invested and, therefore, be motivated to attain.

III. Effective Vocational Programs Provide Opportunities for Clients to Increase Vocational Maturity

The concept of Vocational Maturity (Crites, 1969; Super, 1964) pertains to the overall potential of an individual to choose, obtain, and sustain employment situations compatible with that person's values and competencies. Clients whose vocational development have been interrupted or disrupted by LTMI, often hold views of themselves and the world of work which are often unrealistic and vocationally immature. The unrealistic perceptions of many clients arise from limited or distorted experience in the worker role. They often need new experiences, coupled with assistance in learning from these new experiences, to acquire increased vocational awareness and a clearer understanding of personal occupational potential (Danley, Rogers & Nevas, in press).

IV. Effective Vocational Rehabilitation Programming Provides Activities and Environments That Enhance Self-Esteem

Self-esteem is one of the few personality variables found to be associated with vocational outcome (Anthony & Jansen, 1984). The lack of self-esteem is

both a precursor and an antecedent of LTMI. Thus, for persons to develop the strong sense of self needed for successfully attaining vocational goals, experiences are required that validate the individual's self-image as a competent worker. These experiences include meaningful work for pay at real jobs accompanied by the opportunity to receive feedback on work performance which is accurate, timely, and constructive (Anthony, Cohen & Danley, 1988).

V. Effective Vocational Rehabilitation Programs Practice a Rehabilitation Approach to Diagnosis

The rehabilitation approach to diagnosis has been described as consisting of two parts: 1) Environmental goal setting and 2) Functional assessment (Anthony, Nemec & Cohen, 1986). The process of environmental goal setting involves the client in a series of exploratory and decision-making activities that result in a mutually acceptable, operationally defined statement concerning the setting in which the client will be functioning within a prescribed length of time. An example of an environmental goal statement can be seen at the top of Appendix C. This goal statement is derived from discussions with the client and significant others in the client's world. The goal statement reflects the values of the client as they pertain to occupational tasks, work settings and work conditions (Anthony, Cohen & Danley, 1988).

Research indicates that the best predictors of success for a client in a given environment are the skills of the client and the supports in the client's world (Anthony & Jansen, 1984). Therefore, an assessment of skills and supports is conducted with the client after the environmental goal is established. This prescriptive approach to functional assessment identifies, defines and evaluates the level of the skills and supports the client has in relation to those needed to be successful in a particular environment of choice. Determination of these skills and supports is made following an examination of the demands that will be made by the environment, and a clarification of the demands the client will make of him/herself in relation to the environment. An example of a prescriptive skills assessment of client supports is presented in Appendix D.

VI. Effective Vocational Programs Apply a Psychiatric Rehabilitation Approach to Planning

Planning for a successful vocational outcome means prescribing and scheduling the essential interventions to develop and enhance the critical skills and supports needed to ensure the client's success in the chosen vocational environment (Anthony, Cohen & Danley, 1988). Appendix E is a sample of an ideal VR plan for a person with a psychiatric disability. This plan, highly individualized and specific, includes high priority skills and supports and the specific interventions needed to produce each skill or support. The plan also includes the name of the person or persons agreeing to provide each intervention, proposed and actual dates for intervention delivery, and spaces for the signatures of all involved parties, including the client. Every step of this plan is developed with the client as a full partner so that the client's signature represents the client's understanding of and commitment to participation in the rehabilitation process.

VII. Effective Vocational Programs Offer Psychiatric Rehabilitation Interventions

Since the best predictors of vocational outcome are client skills and environmental supports, the interventions required are those that provide for the development of skills and resources relevant to vocational outcome (Anthony, Cohen & Danley, 1988).

Skill development interventions include those needed to help the client a) acquire missing skills (i.e., those the client can not perform in any setting) and b) use existing skills when and where they are needed. In the first instance, the appropriate intervention is skill teaching. In the second instance, the proper intervention is skill programming (Cohen, Danley & Nemec, 1986). Effective skill teaching involves formal preparation and purposeful instruction, often in a safe or simulated environment. Skill programming involves exploring, identifying and implementing action steps the client can take to eliminate barriers to skill use in a particular setting or situation.

Resource development interventions involve either helping the client to find and use existing resources, or working to change resources so that they become accessible and useful.

VIII. Effective Vocational Programs Provide for Intensified Support During Periods of Transition

Change for anyone is stressful; and rehabilitation, by definition, is fraught with change. Psychiatrically disabled persons often experience heightened symptomatology during times of increased stress (Strauss, Hafez, Liberman, & Harding 1985). During the rehabilitation process, clients may experience many new environments as they progress through vocational preparation and finally attain a chosen vocational placement. At each point, the new setting may present stimuli which precipitate anxiety, and fear that encourage the reappearance of symptoms. It is critical at these transition points to have increased support available to the client. Because clients differ widely, their enlistment of this available support will vary greatly. However, failure to provide the opportunity for increased support can result in inability of the client to adapt to and flourish in the new setting.

The potential need for increased support should be discussed openly with the client during the functional assessment so that, to the degree possible, the need for increased support can be anticipated and included in the rehabilitation plan. However, once the transition is occurring, the VR practitioner should monitor the plan carefully in order to mobilize additional supports if they are needed.

Often, practitioners hesitate to increase support because they fear encouraging unhealthy dependency needs. However a temporary need for increased dependency is normal and may be essential to the achievement of sustained independence from professional helping systems. The intent need not be for the client to be totally self-sufficient; rather, the goal for the client should be to recognize the need for help and request assistance appropriately.

IX. Effective Vocational Programs Permit Participants to Take "Time Off"

For persons who have suffered psychiatric problems, recovery is not linear, nor is progress constant (Strauss et al, 1985). Therefore, a rehabilitation process that presumes a constant linear progress is predestined to fail. Rather, effective programs are flexible in that they allow for periodic withdrawal and re-engagement throughout the rehabilitation

larger each year, with 161,114 served in FY 1986. There should be continuous support and encouragement for these and other employer incentives to expedite employment in the local community for persons with LTMI.

However, incentives to employers can also be viewed in another way. Men and women with LTMI can be valued and fully productive members of the work force. When employers benefit from good workers, there should be no need to provide incentives. Free gifts to induce the sale of a product can cause doubt about the quality of the product. Likewise, since the experience of employers with TE gives ample testimony as to the ability of persons with LTMI to meet employer standards, incentives should be used cautiously and be available only when the employee is producing at less than competitive rates.

Supplemental Security Income and
Social Security Disability Insurance: Work Disincentives

Although disability-related insurance such as SSI and SSDI were established to enable persons with severe disabilities to live in the community rather than in segregated institutions, they present disincentives to achieving productive citizenry among persons with LTMI. In order to qualify for SSI, such persons must prove themselves unable to work as the result of a psychiatric or mental disorder. Estroff (1981) has written that "SSI represents one of the most permanent and visible labels the clients possess. It is the culmination of the chronic client-labeling process" (p. 169). Once in receipt of SSI and related benefits such as food stamps and medical assistance, however, these same persons might experience a life in the community with a certain amount of financial security, as minimal as it may seem to others.

With the advent of services such as SE programs, these same individuals who attested under oath regarding the severity of their work disabilities, are not being told that they can work. However, the financial security which comes with the opportunity for employment is lacking to say the least. Issues such as the following need to be resolved:

- Reinstatement of the client into these entitlement programs as a result of acute episodes of their illness,

- security medical/health insurance above a certain income,

- the lack of insurability under private providers in many instances, and

- the differential treatment of SSI and SSDI recipients with respect to earned income.

Funding for On-Going Services
Where is the long-term support for MH clients coming from? Follow-up, follow-along, post employment or long-term support services are required to place clients with LTMI in SE, and they are essential for the maintenance of any other type of employment. Availability of these services depends upon several factors including local funding, willingness of VR counselors to use post-employment services, and the willingness and capability of MH agencies to provide these services. Localities have dealt with this problem in a variety of ways: State legislation requiring long-term funding; appropriation of funds to MH specifically designated for this purpose; establishment of performance incentives within a VR agency that encourage use of post-employment services; the commitment of funds from charitable organizations such as the United Way; use of SSI or ILC funds for payment of job coaches, etc. Discussion of this issue usually focuses on exchange of dollars. Non-monetary methods utilized include exchange of services from one agency to another, use of peer support groups or work-site support groups. A national conference for sharing and generating ideas on the issue of long-term support services would be useful.

Joint Training and the Interagency Collaboration Process
For the past four years, RSA has actively supported the funding of training programs for VR, MH, and provider agencies at the community level. The consequences of this support have just begun to take hold across the country at large. Also, implementation of interagency agreements, the cross-training of staff as part of the collaboration process on the local community level, the joint funding of projects, etc., have been spurred on by federally funded joint training initiatives largely conducted by University faculty and/or private non-profit agencies.

To discontinue funding for these resources, which have provided for the accumulation of valuable experience and expertise in the field, will drastically alter the momentum for continued and ongoing collaboration in the field. Turning out "specialists" in the VR community to work with persons with LTMI, while a noble and needed training initiative, will not serve in and of itself to further work in interagency collaboration across systems. Because

of its segregating nature. specialized training in VR with no agency support for training in the collaboration process will, in the end, undermine the systems approach to working with persons with LTMI. The history of separate and distinct programs that have focused on the VR of persons with LTMI speaks for itself. Those persons with severe psychiatric disabilities are not highly successful in terms of access to, participation in, and retention of employment. Professionals should be able to assist these persons to access a single system. Evidence is clear that services have not fully met the needs of persons with LTMI. Following are some activities that should be investigated.

Jointly Funded Projects: While RSA and NIMH jointly fund two research and training centers in the area of psychiatric rehabilitation, few other jointly funded projects exist at the national level. Various states, however, have actively engaged in the joint funding of demonstration projects, special initiatives, and discretionary grant programs. The experiences, both positive and negative, of these states should be disseminated widely.

Specific Legislation: To ensure maximum cooperative and collaborative programming and long-range planning, joint federal Legislation should be introduced by those agencies that have legal responsibility for delivering traditional rehabilitation service to persons with LTMI. There should be a closer and more united approach at the federal level in determining priorities, proposed legislation and funding of services.

Public Information and Educational Initiatives: Expanded public information and educational activities are needed at the national, state and local levels to better inform the executive, legislative and judicial branches of government and the general public regarding the employment potential of persons with LTMI.

Higher education should be encouraged to become more involved in research, demonstration and training activities that will result in improved and expanded programming and services to persons with LTMI.

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APPENDIX A

Interdepartment Cooperative Agreement:
Examples of Issues and Concerns Around
Which Agreement Between VR and MH Agencies is Specified

I. LEGAL BASIS

II. PURPOSE (Excerpted from Pennsylvania's latest draft agreement)

The overall purpose of this agreement is to enable the agencies providing treatment, care, and rehabilitation services to persons with psychiatric disability to maintain and improve working relationships at the state and the local level that will increase the efficiency, comprehensiveness and effectiveness of their combined efforts. This agreement recognizes the continued commitment of the mental health and vocational rehabilitation systems to provide vocational services to the severely handicapped. The parties agree that duplication of services by the two agencies must be eliminated where possible. Each agency accepts responsibility for certain segments of service for all mutual clients, while the responsibility for other services is shared.

The parties agree that the ultimate goal of this agreement is to increase employment opportunities for our mutual clients. Whenever possible those work opportunities should be in the competitive labor market, in industry-integrated rehabilitation programs or in client-operated businesses. It is understood that persons with chronic mental illness will from time to time require support in maintaining employment and each agency will work toward ensuring that such services are available as needed. Long term placement in sheltered workshops should be minimized.

This agreement enables two major implementation efforts to take place:

A. The Interagency Agreement Coordinating Committee provides a mechanism for continuing state office level discussion/negotiation to eliminate administrative barriers, to set program direction reflective of current technology in psychiatric rehabilitation, and to bring about overall systems change. The ultimate responsibility for this rests with the Deputy Secretary for Mental Health and the Executive Director of the Office of Vocational Rehabilitation.

B. The local agreement process provides a framework for the continuation and further development of cooperative efforts between VR district offices and county mental health offices to work with consumers, advocates and service providers to establish local goals for improved service delivery and eliminate procedural barriers, the primary responsibility for

this rests with the respective county MH and VR district administrators.

III. RESPONSIBILITIES

A. Interdepartmental Service Planning

1. The development of innovative, alternative service components within the public and private sectors
2. The development of mutual agency goals
3. The development of common data gathering and evaluation systems
4. Joint funding of new and innovative service alternatives
5. Mutual staff development opportunities
6. The development of other projects for mutual benefit

B. Local Agreements

C. Agreement Coordination and Monitoring

1. Ensuring that local agreements are established and maintained
2. Monitoring the effectiveness of local agreements
3. Providing a forum (appeal process) for resolving specific policy and operational issues
4. Recommending changes in statewide policy as necessary to eliminate policy barriers

IV. RESPONSIBILITIES OF THE COUNTY MENTAL HEALTH OFFICES AND THE VR DISTRICT OFFICES

A. Local Agreement Requirements

1. Liaison and Referrals
2. Rehabilitation Case Team
3. Office Space
4. Services
5. Information Exchange
6. Mutual Service Goals and Evaluation
7. Mutual Fees
8. Staff Development
9. Conflict Resolution
10. Local Agreement Review

B. Local Agreement Implementation Considerations

1. Basic Procedure
2. Referral Information Package
3. Eligibility
4. Determination of "Reasonable Expectation" - Criteria for referral to VR

5. Rehabilitation Program Planning
6. Progress
7. Maintenance
8. Placement
9. Post Employment Services

INTERAGENCY COOPERATIVE AGREEMENT
DEPARTMENT OF HUMAN SERVICES - MENTAL HEALTH DIVISION (DHS-MH)
AND
DEPARTMENT OF JOBS AND TRAINING
DIVISION OF REHABILITATION SERVICES (DJT-DRS)

I. PURPOSE

A joint commitment enabling the DHS-MH and DJT-DRS to improve the coordination and quality of support and VR services available to persons with serious and persistent MI.

II. GOALS

A. Increase cooperative planning, problem solving, information sharing and service coordination among VR and MH practitioners and administrators.

B. Develop local teams of providers of VR and MH services to address the interrelated and individualized needs of persons with severe persistent MI.

C. Develop systems of ongoing support services and case management for persons with serious and persistent MI to ensure greater vocational stability and employment success.

D. Increase understanding among practitioners and administrators of the special needs of persons with dual disabilities (e.g., chemical dependency and MI).

III. COOPERATIVE ACTIVITIES

A. Interagency Planning

Cooperative planning and problem solving involving MI and VR administrators is accomplished by meeting on a regular basis. A recommended schedule is:

* Assistant Commissioner - semi annual
* State Agency Program Directors/Representatives - quarterly
* Designated agency liaisons - monthly or more often as needed

B. Cooperative Service Delivery

Cooperative planning and problem solving to coordinate programs and the delivery of rehabilitation, MH and case management services can be accomplished in the community by meeting on a regular basis. DJT-DRS and DHS-MH will encourage the following meeting schedules:

* DRS Area Management Specialists or Counseling Supervisors with county social services, and Community Support Program Directors - quarterly
* DRS Counselors with County Case Managers, Community Support Program staff, MH Clinic staff, Regional Treatment Center staff and other local providers - quarterly or more often as needed
* All managers, supervisors and direct service staff are encouraged to attend meetings of local Mental Health Advisory Committees at least annually.

C. Interagency Program Development

1. Joint Grant Applications and Funding Proposals. Representatives of DHS-MH and DRS will work together in developing funding proposals to various public and private funding sources.

2. Reciprocal Grant Review Process

   a. Administrative representatives of DRS will be invited to participate in the review of Rule 14 and Rule 12 funding proposals submitted to DHS-MH with attention to coordinating the employability components of these grants.
   b. Administrative representatives of DHS-MH will be invited to participate in the review of Supported Employment, Independent Living, and Community Based/ Long-Term Sheltered Employment funding decisions at DJT-DRS with attention to the MH components of these proposals/requests.

D. Coordinated Biennial Budget Development

1. DHS-MH and DRS will jointly determine needs in preparation of both agencies' Biennial Budget Request.
2. DHS-MH and DRS will exchange Biennial Budget Request documents prior to submission to the legislature for purposes of analyzing their impact and will support those portions of mutual interest or benefit to persons with serious and persistent MI.

E. Training and Technical Assistance

1. DHS-MH and DRS will continue to cooperate in presenting information at regional or statewide conferences, workshops or other forums offering an opportunity to share information regarding the rehabilitation treatment and support of persons with serious and persistent MI.

2. DHS-MH and DRS will continue to promote team building among MH, rehabilitation and case management professionals at the local community level, as the preferred approach to

serving persons with serious and persistent MI. This will be encouraged by offering technical assistance to local providers.

F. Information and Data Exchange

DJT-DRS and DHS-MH will continue to exchange incidence and prevalence data, resource directories and listings, needs analysis information, service provision and outcome data, funding information, technical reports, legislative information, research findings and professional literature relating to the rehabilitation and treatment of persons with serious and persistent MI.

G. Cooperative Funding and Special Efforts

DHS-MH and DJT-DRS will continue to pursue the joint development, delivery and evaluation of special projects and innovative approaches to meeting the vocational, MH and support service needs of persons with serious and persistent MI.

DHS-MH and DJT-DRS have special interest in the provision of supported employment to persons with severe and persistent MI and will explore the potential for a collaborative agreement under Title VI C of the Rehabilitation Act to expand access to that service.

IV. TERMS OF AGREEMENT

A. Amended by mutual written consent of the two agencies.
B. Effective as of January 1, 1988 for a period of 2 years, expiring on December 31, 1989.
C. Either party may terminate this agreement by providing 30 days advance notice in writing to the other party.

_____ _____

Allyson Ashley
Assistant Commissioner
Department of Human Services
Mental Health Division

Date

_____ _____

William Niederloh
Assistant Commissioner
Department of Jobs and Training
Division of Rehabilitation Services

Date

AGREEMENT OF COOPERATION
BETWEEN THE
DIVISION OF VOCATIONAL REHABILITATION OF THE
MARYLAND STATE DEPARTMENT OF EDUCATION
AND THE
MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

I. PURPOSE

This plan of cooperation is entered into between the Division of Vocational Rehabilitation of the Maryland State Department of Education (herein referred to as DVR) and the Maryland State Department of Health and Mental Hygiene (herein referred to as DHMH) for the purpose of establishing practical and effective working relationships between the two agencies in coordinating services to eligible disabled citizens of the State of Maryland.

It is mutually agreed that adequate preparation of disabled persons for suitable employment is both wise and economical. Diagnosis, vocational evaluation, treatment, vocational preparation and other rehabilitation services must go hand-in-hand and are best provided in a coordinated manner.

The desire of DVR and DHMH to coordinate their efforts in providing services to eligible persons results in the following purposes of this Cooperative Agreement:

A. To define the role and function of each agency participating in this agreement;

B. To define the responsibilities of each agency;

C. To designate agency staff members responsible for orderly implementation and recommendation of improved methods of providing services.

II. LEGAL BASIS

The coordination of programs serving disabled individuals and the development of cooperative agreements between these programs have the following bases in federal and state law:

- Rehabilitation Act of 1973 as amended by PL 95-602, Sections 101(a) (11), 101(a) (12);
- 34 Code of Federal Regulation, Part 361, Sections 361.11, 361.13 and 361.19;
- 42 Code of Federal Regulations, Part 431, Subpart M;
- 42 Code of Federal Regulations, Sections 2.1 to 2.67-1;

- Public School Laws of Maryland, Title 13A, Bylaw 13A.05.02.01;

- Code of Maryland Regulations, Maryland Health General Article 6 (1982) Sections 7-610 to 7-614, 8-511, 9-206, 9-802 and 10-712.

III. ROLE AND FUNCTION OF EACH AGENCY

A. Division of Vocational Rehabilitation

DVR is the official State Agency responsible for providing to disabled individuals determined to be eligible, vocational rehabilitation services and occupational placement opportunities consistent with the assessed needs and abilities of the disabled individual. It is responsible for assessing the vocational potential of disabled citizens in Maryland and providing services to assist them in entering or re-entering the employment arena.

B. Maryland State Department of Health and Mental Hygiene

DHMH is the official State Agency responsible for providing comprehensive health care services to certain medically indigent residents of the State of Maryland including individuals with disabilities of mental retardation, mental illness, addictions and/or developmental disabilities. In addition DHMH provides in conjunction with each local Board of Education a school health program (Section 7-401 of the Public School Laws of Maryland) for all public school students, regardless of health or socioeconomic status.

IV. RESPONSIBILITIES OF EACH AGENCY

A. Division of Vocational Rehabilitation

In responding to the vocational needs of eligible disabled individuals, DVR will provide the following services as appropriate:

1. Determine eligibility based on the following federal criteria:

   a. The presence of a physical or mental disability which for the individual constitutes or results in a substantial handicap to employment

   b. A reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability.

2. Medical and psychological examinations

3. Vocational evaluation
4. Vocational counseling and guidance
5. Physical restoration
6. Vocational training
7. Placement and follow-up

In addition to the employment related services identified above, DVR administers the Disability Determination Service (DDS) which is responsible for adjudicating Social Security and Supplemental Security Income disability claims filed under Title II and Title XVI of the Social Security Act.

DDS provides the following services:

1. Gathers medical evidence from treatment sources on disability claims received from the local Social Security district offices in Maryland;
2. Provides consultative medical and/or psychological evaluations on claims with insufficient evidence;
3. Collects vocational evidence pertinent to adjudication of the disability claim;
4. Evaluates all evidence to make determinations of eligibility for Social Security Disability Insurance and/or Supplemental Security Income based on Federal Regulations;
5. Refers disability claimants for vocational rehabilitation services.

B. Maryland State Department of Health and Mental Hygiene

In responding to the health needs of disabled individuals, DHMH, through its various Administrations and programs provides the following services subject to availability of funds:

1. Health Education
2. Outpatient Health Services
3. Inpatient Health Services
4. Payment of certain medical costs through the Medical Assistance and Pharmacy Assistance payment programs and the Crippled Children's Program
5. Community based treatment for various disabilities

C. Services Provided by Both Agencies

In addressing the vocational needs of eligible disabled individuals, joint planning by the rehabilitation professionals of each agency is important for developing a comprehensive plan of services and avoiding duplication of services. DVR will be responsible for determining the vocational potential of disabled individuals and for developing with eligible

individuals, an Individualized Written Rehabilitation Program (IWRP) to assist the individual in obtaining employment. Specific services to be provided by DVR, based on the needs and abilities of the individual, will be identified in this jointly developed program.

DHMH will be responsible for developing and maintaining an after care plan for individuals discharged from State hospitals and for providing services to clients under a continuum of care model. Mental health services are provided at local community health centers or through purchased or grant funded methods (i.e., psychosocial services). Summary reports of the disabled individual's progress in treatment provided through these sources will be provided to DVR when the individual is referred provided a written consent for sharing this information is provided by the client.

Services to disabled individuals under age 21 will be provided by DHMH when it is determined through clinical assessment and diagnosis that the individual has an organic disease, defect, or condition (whether congenital or acquired through diseases, accident or a flaw in development) which may hinder the achievement of normal growth and development.

V. AREAS OF COOPERATION

A representative from each agency shall be designated to serve as a liaison person to collaborate in preparing amended and/or supplemental agreements, exploring resources, and establishing controls and procedures that will effect satisfactory execution of this agreement. The liaison persons will evaluate procedures and working relationships and will prescribe such action as will realize the above objectives. The liaison representative of the DHMH will be the Secretary or his/her designee. The liaison representative of the Division of Vocational Rehabilitation will be the Assistant State Superintendent or her/his designee.

Referrals by DHMH to DVR will be made to the local DVR office in the geographical area of the state in which the disabled individual resides. In determining the appropriateness of the referral to DVR, DHMH staff will refer only those disabled individuals who voluntarily agree to such a referral and who may benefit from DVR services. All referrals shall be accompanied by a written authorization which complies with all applicable federal and state laws authorizing the transmittal of necessary information.

Individuals who have diagnosed disabilities of drug or alcohol abuse and who desire services provided by DVR, must have demonstrated their ability to control their substance abuse problem by having the referral agent certify that the applicant has the drug

or alcohol abuse under control and is actively involved in an approved treatment program.

To provide an effective working relationship there will be exchanges of information and access to client records between the DVR and the DHMH. Every effort will be made to preserve the confidential nature of case material and all exchange of information and access to client records will be in accord with the Federal Privacy Act, Chapter 57, 34 Code of Federal Regulations, Part 361.49, 42 Code of Federal Regulations 2.1 to 2.67-1 and all applicable Maryland Law.

DVR in compliance with 34 Code of Federal Regulations, Part 361.47 must give full consideration to any similar benefits available under any program to a handicapped individual to meet, in whole or in part, the cost of physical and mental restoration services, and maintenance and training in institutions of higher education unless it would significantly delay the provision of services to an individual.

In compliance with this, DHMH agrees to provide first dollar payment, at its established rates when medical services are provided to clients of DVR who are eligible for Medical Assistance, Pharmacy Assistance, or Crippled Children's benefits and the provider of service participates in the Medical Assistance or Pharmacy Assistance program. (First dollar payment means that DHMH will pay for authorized medical services to eligible individuals. DVR funds will be spent on these medical services only if the services is not covered by the Medical Assistance, Pharmacy Assistance or Crippled Children's Program.) It is also agreed that when DHMH makes payment to a provider for a covered service, no additional payment for such service may be received by the provider from the individual receiving services or from any other source, except for such recoveries as may be allowed pursuant to the regulations and guidelines of the Medical Assistance or Pharmacy Assistance Programs (eligible individuals may contribute to the cost of pharmaceutical products).

DVR will refer individuals who may be eligible for Medical Assistance or Pharmacy Assistance Program benefits to the local Department of Social Services to make application for such benefits.

The needs of disabled individuals will be met to a greater extent if there is mutual understanding by the personnel of both agencies of the facilities, resources and programs available. This will be accomplished through joint training and staff conferences, mutually arranged, for exchanging information concerning functions and responsibilities of personnel. The responsibility for scheduling such training and other conferences will be vested in the liaison personnel.

The Maryland Division of Vocational Rehabilitation and the Maryland State Department of Health and Mental Hygiene comply fully with all of the provisions and regulations issued thereunder, which provide that equal services shall be available to all eligible citizens regardless of race, religion, sex, national origin or handicapping condition. The Division of Vocational Rehabilitation will not render payment to the local Health Department for services rendered. Should the individual client's income be such that payment would be expected by the local Health Department according to their fee schedule, such payment will come from the client.

VI. MONITORING PROVISIONS

The parties to this Agreement realize that it will be necessary periodically to review and revise it as necessary based on changes in law and/or improved methods of providing services. A review will be conducted at least annually by the liaison person of each agency, or their representatives. It may be amended upon written agreement of all parties or as amendments to the law may require it.

The Cooperative Agreement between the Maryland Division of Vocational Rehabilitation and the Maryland State Department of Health and Mental Hygiene effective June 1, 1984 to May 31, 1987, has been reviewed by the undersigned. This Agreement satisfactorily defines the working relationships between the two agencies for the purpose of providing maximum service to disabled individuals.

Maryland Division of Vocational Rehabilitation		Maryland State Department of Health and Mental Hygiene	
Richard A. Batterton Assistant State Superintendent	Date	Adele Wilzack, R.N. Secretary	Date
Jim Fitzpatrick Staff Specialist Field Operations DVR Initiator of Agreement	Date	Dr. Avrum Shavrick Director of Education DHMH Initiator of Agreement	Date

APPENDIX B

Definitions of Severity Classifications

(1) Severe disturbances of thinking and behavior that entail potential harm to self or others; or

(2) In the extreme, severe disturbances of all components of daily living, requiring constant supervisions in category #1, with the provision of rehabilitation services may be capable of maintaining themselves in the community and to engage in limited or sporadic productive activity only under continuing supervision in sheltered or protective environment, including halfway houses. Unable to communicate readily, have difficulty differentiating between fantasy and reality, behavior is disruptive and often menacing to others, engage in shouting, exhibit vulgarity, careless about dress and excretary functions, may make suicidal attempts necessitating continuing observation, professional intervention and medication, especially during early stages of rehabilitation process.

NON SEVERE

Psychoneurotic disorders not now requiring institutional care in a mental hospital or psychiatric ward of a general hospital and with no history of being institutionalized for treatment for three (3) months or more or on multiple occasions;

or

Stress reactions to daily living without substantial loss of personal or social efficiency. With the provision of rehabilitation services, can maintain independent living in the community and engage in competitive employment. Can accept direction, maintain adequate interpersonal relations and concentrate sufficiently to perform job requirements. Only under occasional conditions of particular internal, social or economic stress will require supervision, guidance and support after placement.

SEVERE

Psychoneurotic disorders with stress reaction which modify patterns of daily living. Can maintain themselves in the community and perform adequately in low-stress competitive employment with the provision of rehabilitation services. May require medication and continuing supervision, motivation and support at least during early post placement. Their fears, indecision, loss of interest or occasional odd behavior will be evidenced during the rehabilitation process, and may moderately interfere with the job performance and

other worker's activities in employment when stressful situations arise.

MOST SEVERE

Psychoneurotic disorders now requiring institutional care in a mental hospital or psychiatric ward of a general hospital or with a history of being institutionalized for treatment for three months or more or on multiple occasions.

and/or

Stress reactions to daily living that result in continuing regression and tissue-organ pathology. Capable of productive work but only under sheltered, non-competitive conditions in a highly structured or protective environment, at least initially. May require continuing medication. Bizarre and disruptive behavior, loss of interest in activities of daily living and problems with memory and concentration will be evident both in the counseling process and in interaction with other workers, thus necessitating continuing supervision, guidance, reactions, motivation and support by professional staff in the work situation. Conversion reactions, poor eating and cleanliness habits may create considerable health problems.

NON-SEVERE

Other mental disorders (i.e., Personality Disorders) which do not meet the conditions of a more severe description.

SEVERE

Other mental disorders (i.e., Personality Disorders) with a demonstrated inability to remain on any full-time job (requiring six or more hours of work per day) for more than three months during the preceding year due to one or more of the following types of behavior which is attributable to the disorder: (1) repeated interpersonal conflicts on the job, (2) inefficient work performance, (3) persistent self-defeating behavior on the job, in job interviews, and/or in applying for jobs, (4) hospitalization for treatment of the disorder, and/or (5) other job-related behavior consistent with the disorder. Such a person requires multiple services (which will include a structured program to modify behavior) planned to be provided over a period of time in excess of 12 months.

APPENDIX C

FUNCTIONAL ASSESSMENT CHART

Name: Eddie

Overall Vocational Rehabilitation Goal: To work at the Comet Supermarket Warehouse through January, 1987.

+/-	CRITICAL SKILL	SKILL USE DESCRIPTION	SKILL FUNCTIONING[1]			
			Spontaneous Use		Prompted Use	Performance
			Present	Needed	Yes/No	Yes/No
+	Dressing	Number of days per week Eddie puts on clothing which matches the requirements of his work task in his apartment between 7:00 a.m. and 7:30 a.m. weekdays before leaving for work.	5	5		
-	Clarifying Directions	Percent of times per week Eddie requests additional information when he is confused by instructions given by the work supervisor at the job site.	0	80%	X	
-	Requesting Social Contact	Percent of time per week Eddie asks someone to spend time with him when he is doing nothing during breaks or after work.	0	75%	X	X

[1]The client's skill level is evaluated in three different ways. The Spontaneous Use column indicates the client's highest present level of use of the skill in the particular environment as compared to the needed level of skill use. The Prompted Use column indicates whether the client can (Yes) or cannot (No) perform the skill when asked to in the particular environment. The Performance column indicates whether the client can (Yes) or cannot (No) perform the skill outside of the particular environment. If the client's present (P) level of spontaneous skill use is zero, then prompted use is evaluated. Similarly, if the client has been evaluated as unable to use the skill when prompted (No), then skill performance is evaluated.

Reprinted from Anthony, W. A., Cohen, M. R., and Danley, K. S. (1988). The psychiatric rehabilitation model as applied to vocational rehabilitation. In Vocational Rehabilitation of Persons with Prolonged Mental Illness. Ciardello and Bell (Eds.) Baltimore, MD: Johns Hopkins University Press.

APPENDIX D

RESOURCE ASSESSMENT CHART

Name: Eddie

Overall Vocational Rehabilitation Goal: To work at the Comet Supermarket Warehouse through January, 1987.

CRITICAL RESOURCES	RESOURCE USE DESCRIPTIONS	USE PRESENT	USE NEEDED
- Supportive Supervisor	Number of times per week job site supervisor praises Eddie for completing tasks.	0	1
+ Recreational Facility	Number of days per weekend staff open the Recreational Center between 10:00 a.m. and 10:00 p.m.	2	2
- Social Contact	Number of days per week friends phone Eddie to talk for 10 minutes or more.	1	5

Reprinted from Anthony, W.A., Cohen, M.R., and Danley, K.S. (1988). The psychiatric rehabilitation model as applied to vocational rehabilitation. In Vocational Rehabilitation of Persons with Prolonged Mental Illness. Ciardello and Bell (Eds.) Baltimore, MD: Johns Hopkins University Press.

APPENDIX E

Vocational Rehabilitation Plan

Name: *Eddie*

Overall Vocational Rehabilitation Goal: *To work at the Comet Supermarket Warehouse through January 1987*

DEVELOPMENT SKILL	OBJECTIVE RESOURCE	NAME	INTERVENTION PRESCRIBED	PERSON(S) RESPONSIBLE	STARTING DATE PROJECTED	STARTING DATE ACTUAL	COMPLETION DATE PROJECTED	COMPLETION DATE ACTUAL	SIGNATURES
X		Clarifying Directions	Skills Programming	Job Coach	Sept. 15		Oct. 15		
	X	Social Contact	Resource Coordination	Mental Health Case Manager	July 6		Sept. 15		
X		Requesting Social Contact	Direct Skills Teaching	Work Adjustment Counselor	August 1		Sept. 15		
	X	Supportive Supervisor	Resource Modification	Vocational Rehabilitation Placement Supervisor	July 6		August 15		

Plan Development Date: *June 30, 1986*

Plan Review Date: *October 1, 1986*

Rehabilitation Client: _____

Plan Developer: _____

Reprinted from Anthony, W. A., Cohen, M. R., and Danley, K. S. (1988). The psychiatric rehabilitation model as applied to vocational rehabilitation. In ***Vocational Rehabilitation of Persons With Prolonged Mental Illness***. Clardello and Bell (Eds.) Baltimore, MD: Johns Hopkins University Press.

APPENDIX F

Training for LTMI Service Providers

If the growing numbers of persons with LTMI who apply to MH and VR for help are being underserved; one reason is lack of trained personnel. The needs of this group are complicated, requiring the services and expertise of practitioners at all staff levels and from a broad range of disciplines. Therefore, any training program that will effectively prepare service providers to work with clients who have LTMI must include multidisciplinary goals and objectives.

Figures 6, 7, and 8 provide guidelines for designing a training program.

Figure 6

ELEMENTS OF TRAINING

Participating Staff

1. agency administrators
2. upper and middle management
3. field and facility supervisors
4. rehabilitation counselors
5. support staff (adjustment services personnel, vocational evaluators, psychologists, medical staff, placement, recreation, dorm supervisors, etc.)
6. clerical staff

Part of the planning should include recommendation for ongoing training in the agency in which the programs are presented.

Content

Several general and specific areas of information and services should be included in the content of the training program.

Information:
1. LTMI population
2. history
3. philosophy
4. legislative perspective
5. collaboration of efforts

Services:
1. administrative issues and concerns
2. continuum of services
3. special needs of clients with LTMI
4. staff concerns and issues
5. the vocational rehabilitation process
6. resources

Figure 7

Prospective Program on Serving Persons With Long-Term Mental Illness

Day 1

- 1/2 hour — Introduction and Orientation
- 1 hour — Purpose, Objectives & Pre-Program Evaluation
- 1 hour — Description of the LTMI Population
- 1 1/2 hour — VR/MH Collaborative Efforts
- 1 hour — Administrative Issues

Day 2

- 1 hour — Continuum of Services
- 1 hour — Special Needs
- 1 hour — Staff Concerns
- 1 hour — Serving LTMI Clients Through the Vocational Rehabilitation Process
- 1 hour — Mental Health: A Valuable Resource
- 1/2 hour — Evaluation and Closure

Figure 8

TRAINING MODULE

Enhancing The Rehabilitation of Persons With LTMI

CONTENT	OUTCOME	METHODS/MATERIALS	TRAINERS
Orientation/ Welcome	Trainee's will be made aware of workshop goals/objectives. Why they were selected to attend. What the training is about. What will be learned. How it can be used.	Registration Forms Lecture IRI Manual	Staff Development Supervisor Training Coordinator
Overview of the LTMI Population	Participants will be provided with a historical perspective of LTMI clients. Will be introduced to concerns and relevant issues in the provision of services to this clientele.	Audio/videotapes Overheads Handouts IRI Manual Selected Literature	Staff Development Supervisor Psychologist Training Coordinator Agency Administrative Staff MH Personnel
The LTMI Population	Trainees will be given information which will help gain understanding of LTMI and who and how the agency will serve these clients.	Lectures IRI Manual Handouts, Films Small Groups	Agency Administrators MH Specialists VR Counselors
Administrative Issues and Concerns	Participants will become aware of critical issues and concerns of agencies/organizations in implementing services to persons with LTMI. Implementing VR/MH collaborative efforts.	Lectures Overheads Audio/videotapes	Agency Administrators Program Managers Supervisors
Provision of Rehabilitation Services	Trainees will be provided information about agency policies regarding referral, screening, diagnosis, eligibility, severity of disability, needed services and placement.	Lectures Large/Small Group Discussion IRI Manual, Agency Manual Regulations & Guidelines Selected Handouts	Staff Development Personnel Program Managers Supervisors
Resources	Participants will receive information about different models, programs, and services which they can contact for assistance and suggestions/ recommendations for serving this population.	Lecture Handouts IRI Manual	Staff Development Supervisors Training Coordinator
Wrap-up, Evaluation & Adjustment			Staff Development Supervisors Training Coordinator

APPENDIX G

RESOURCES

The following resources are geographically representative of organizations that provide excellent information on programs, services, and other functions discussed in this document. Most of the organizations listed have been in existence for a number of years and appear likely to continue. All have agreed to provide information and assistance when requested. Readers who contact these resources will be able to obtain further information on various topics as well as a list of additional resources related to their specific needs.

A summary of each organization is provided, beginning with a brief description of the unique feature that led to its inclusion in this document. This is followed by information on the organization, its functions that are most relevant to this document, and a summary of the kinds of information that organization can provide.

To assist readers in deciding which resources are relevant to their specific interests, codes for various organizations and their functions are printed to the right of the organization's name. An explanation of these codes is provided below.

CO	Consumer/Advocacy Organization	Provides a wide variety of information and services to meet the interests of consumers, their families, and other advocates
FU	Funding Resource	Provides grants/contracts for developing, researching, and disseminating information about effective service provision
IA	Interagency Collaboration	Develops and implements collaborative relationships with one or more agencies in order to improve service delivery
IC	Information Clearinghouse	Systematically gathers, stores, and disseminates information upon request
IR	Information Resource	Provides information related to service provision, program development, and research, upon request
PO	Professional Organization	Serves the mutual interests of service providers

RE	Research Organization	Conducts projects designed to document the efficacy of service programs and systems
RM	Resource Materials	Produces books, audio-visual, and training materials
SP	Service Programs	Provides direct services--may experiment with and develop program models
TA	Technical Assistance	Consults with other service providers to improve service delivery
TR	Training Organization	Provides instruction in knowledge and skills to improve service delivery

The organizations within the Resource Chapter are grouped by region, beginning with Region I. Within each regional section, organizations are listed alphabetically by state and alphabetically by organizational name within states.

The following directory provides a complete alphabetical listing of all resources with their organizational codes and appropriate page numbers.

PAGE	ORGANIZATION	CO	FU	IA	IC	IR	PO	RE	RM	SP	TA	TR
119	Albert Einstein R&T Center for the Psychiatrically Disabled							X		X	X	X
135	AMI of Rock Island & Mercer Counties Voc. Development								X	X		
138	Arkansas R&T Center in Vocational Rehabilitation							X	X		X	X
115	Boston University Center for Psychiatric Rehabilitation							X	X	X	X	X
123	Brookes Publishing Company								X			
143	Colorado Division of Rehabilitation			X						X		
134	Community Friendship, Incorporated									X		
149	Community Psychiatric Clinic									X		
143	Consumer Case Manager Program									X		
147	Employment Network Project				X						X	X
133	Fellowship House								X	X	X	X
120	Fountain House, Incorporated							X	X	X	X	X
117	Green Mountain Work Force									X		
119	Harbor House									X		
115	Incentive Community Enterprises, Incorporated									X		
142	Independence Center									X	X	X
152	Independence House			X						X		X
129	International Association of Psychosocial Rehabilitation Svcs						X		X		X	
140	Jackson Street Fairweather Program									X		
133	Job Accommodation Network				X							
151	Job Training Partnership Act		X									
124	Johns Hopkins University Press								X			
150	Kitsap Initiatives									X		
147	Laurel Hill Center								X	X		

BEST COPY AVAILABLE

PAGE	ORGANIZATION	CO	FU	IA	IC	IR	PO	RE	RM	SP	TA	TR
126	Matrix Research Institute							X	X		X	X
130	National Alliance for the Mentally Ill	X							X			
145	National Alliance of Mental Patients	X			X				X			
121	National Association of Rehabilitation Facilities				X		X		X		X	
151	National Directory of Fairweather Programs				X							
124	National Institute of Mental Health		X					X	X			
122	National Institute on Disability & Rehabilitation Research		X			X		X				
130	National Mental Health Association	X				X			X		X	
126	National Mental Health Consumers Association	X			X				X		X	X
131	National Rehabilitation Association						X		X			X
139	Oklahoma Department of Mental Health			X		X				X		
148	Oregon State University							X	X	X		X
127	Pennsylvania Office of Vocational Rehabilitation			X						X		
141	Phoenix House, Incorporated									X		
146	Portals									X		X
138	Program for Assertive Community Treatment							X		X	X	X
122	Rehabilitation Services Administration		X			X						
137	Rise, Incorporated								X	X	X	X
116	Robert Wood Johnson Foundation		X					X	X			
144	Rocky Mountain Resource & Training Institute							X	X		X	X
125	Schapiro Training & Employment Program								X	X		
118	Set Industries									X		
132	Social Center for Psychiatric Rehabilitation									X	X	
136	Thresholds							X	X	X	X	X
128	Western Psychiatric Institute & Clinic							X	X	X	X	X

REGION I

Boston University
Center for Psychiatric Rehabilitation
730 Commonwealth Avenue
Boston, MA 02215
(617) 353-3549

RE, TR, TA, RM, SP

Contact: Director, Information Services Branch

UNIQUE FEATURE:

Research and training in knowledge, skills, and attitudes critical to psychiatric rehabilitation. Service program uses the University as an integrated rehabilitation setting.

ORGANIZATION:

The Center for Psychiatric Rehabilitation is a research, training and services division of the Rehabilitation Counseling Department, Sargent College of Allied Health Professions, Boston University. The Center houses a Rehabilitation Research and Training Center in Psychiatric Disability. The Center contributes to psychiatric rehabilitation through research, materials development, knowledge dissemination, training and technical assistance. Service programs are operated as a means of developing and evaluating innovative psychiatric rehabilitation technologies. Research and training projects at the Center are funded through the National Institute for Disability and Rehabilitation Research in conjunction with the National Institute for Mental Health. The Center also maintains a data base and operates an electronic bulletin board service to alert consumers and providers of community support and rehabilitation services to useful resources.

INFORMATION/MATERIALS AVAILABLE:

The Center publishes and disseminates articles on psychiatric rehabilitation as well as a quarterly newsletter, the Community Support Network News. Psychiatric rehabilitation training packages, including video and audio-tapes and instructional materials, are available for purchase. A catalogue of Center products is also available. On a contractual basis, staff provide in-service training, technical assistance and consultation. The Center sponsors a national conference annually and offers a series of workshops throughout the year. In conjunction with the International Association of Psychosocial Rehabilitation Services, the Center publishes the Psychosocial Rehabilitation Journal.

Incentive Community Enterprises, Inc.
441 Pleasant Street
Northampton, MA 01061
(413) 584-1460

SP

Contact: Vice President of Employment and Training

UNIQUE FEATURE:

One of the largest free-standing surveyors of supported employment (SE) in a variety of settings.

ORGANIZATION:

Incentive Community Enterprises has two service divisions -- AIM, the community living services division, and I.C.E., the SE division. I.C.E. replaced its network of five sheltered workshops with a SE system. Services are provided at ten different community offices throughout Massachusetts and Connecticut.

Each local SE system involves a range of SE models. Enclaves are provided for people who are more severely disabled, but generally employment is supported in more integrated settings. These include transitional employment (TE) placement on an on-the-job training (OJT) basis; coached individual placements; and small group settings involving present or visiting on a circuit basis. I.C.E. also runs five small affirmative industries--two restaurants, a copy center, a plaza maintenance business, and a soda sales and bottle redemption shop.

Agency philosophy identifies unemployment as the problem faced by I.C.E. clients. Industry and employers are recognized as holding the solution to the problem. Agency resources are dedicated to creatively connecting the unemployed individual with the employer/business. Thus the role of I.C.E. is mainly that of a broker, constantly identifying new and creative ways to make this connection.

Recently, I.C.E. established an innovative college-based employment preparation program. Individuals with severe disabilities participate in a college hotel/restaurant program. Participants attend classes during three days a week using college juniors as coaches; on the other two days, participants work in local restaurants. This program has the advantage of introducing future restaurant managers to individuals with disabilities as an employee resource. The hotel/restaurant program, which has been operating at the University of Massachusetts since 1986, has now been replicated at Manchester Community College in Connecticut.

INFORMATION/MATERIALS AVAILABLE:

Staff speak at conferences throughout the country. Copies of publications and consultation are available. Telephone inquiries welcome.

The Robert Wood Johnson Foundation — FU, RE, RM
Program on Chronic Mental Illness
74 Fenwood Road
Boston, MA 02115 (617) 738-7774

Contact: Deputy Director or Communications Director

UNIQUE FEATURE:

Funding resource for service and research projects in the health fields.

ORGANIZATION:

A national philanthropy that has awarded grants in excess of $900 million since 1972 for improvement of health care in the U.S. Collaborating with the Department of Housing and Urban Development in providing grants and loans to nine cities selected to participate in a new initiative to improve service delivery to persons with LTMI. The nine cities include Austin; Baltimore; Honolulu; Columbus, Cincinnati, and Toledo, Ohio; Charlotte, NC; Philadelphia and Denver. Projects focus on the organization and financing of systems of care in large urban areas, developing new service models in housing, employment, case management, and continuity of care.

INFORMATION/MATERIALS AVAILABLE:

Can refer to the nine demonstration projects and the appropriate contact person. Can provide information on various service models being tried in the nine cities. Limited ability to consult or make presentations on these models. Publishes a quarterly newsletter about the projects, as well as monographs around topic areas such as housing or financing. Recently published a housing manual, Housing for People with Mental Illness: A Guide for Development, based on the program's experience, that provides practical information on locating and funding community-based housing options.

Green Mountain Work Force SP
5 Court Street
Montpelier, Vermont 05602
(802) 223-6355

Contact: Program Director

UNIQUE FEATURE:

Developed effective job support services to enable persons with LTMI to maintain long-term employment.

ORGANIZATION:

A psychosocial rehabilitation program run by Washington County Mental Health Services, Inc. Provides a wide variety of services to persons with LTMI. Operates a small workshop component that provides skill training in computers, food service, and clerical skills. Work crews provide opportunities for lawn maintenance and housekeeping jobs. Community-based employment in transitional or supported placements are developed through effective employer relationships. Use of seasonal ski resorts offers natural temporary or transitional employment placements.

Key to the program's success is the development of a community support team. Team members do job development, job placement, provide on-the-job training, and long-term support. Job support services are provided on or off the worksite, at the preference of the client. The promise of on-call support to employers has led to excellent employer relationships, and the provision of such services has allowed some clients to remain with the same employer for three or four years.

INFORMATION/MATERIALS AVAILABLE:

Willing to share information on this agency's experience in developing and marketing TE and SE positions, and in providing long-term supported services. A brochure oriented toward employers is in process.

Set Industries SP
P. O. Box 501
Hardwick, VT 05843
(802) 472-6107

Contact: Company Manager

UNIQUE FEATURE:

Rehabilitation company experimenting with implementation of voucher system.

ORGANIZATION:

A private rehabilitation company affiliated with a consulting company that provides businesses with non-disability related supervisory training. Awarded an SSA grant to develop and implement a voucher system and to demonstrate the effectiveness of such a system of enabling people to enter the work force. The pilot project involves multiple disabilities, including people with LTMI, and provides a base for larger future projects.

The voucher awarded to each participant is used as collateral in multiple financial collaborations to build a fund several times the initial award. The resulting fund is used to finance the participant's rehabilitation plan. The client purchases services, selecting from available public or private vendors and purchasing support services when needed.

INFORMATION/MATERIALS AVAILABLE:

The company manager can provide information about the project itself, voucher systems, and collaborative financing. Printed materials about the project will be available in May 1989.

Harbor House SP
St. Joseph's Hospital/Medical Center
703 Main Street
Patterson, NJ 07503
(201) 977-2155

Contact: PWI Coordinator

UNIQUE FEATURE:
Funds TE program with Projects With Industry grant.

ORGANIZATION:
A CARF accredited clubhouse program that provides case management, pre-vocational, vocational, employment, post-employment, housing, and advocacy services. Works with LTMI of diverse ethnic backgrounds. Most clients are between the ages of 25 and 35, have a diagnosis of schizophrenia, often accompanied by substance abuse, and have little or no work history.

Received a PWI grant in 1983 that funds their TE program with ten employers. PWI staff do job development and job placement. Recently awarded an RSA recreation grant to enhance member's integration into community social activities and to provide support for vocationally active members.

INFORMATION/MATERIALS AVAILABLE:
Can answer questions about this agency's process and format for approaching employers, methods of evaluating whether the employer meets their needs, job accommodations made for this population, and the progression of placements from extremely supportive to independent.

Albert Einstein Rehabilitation RE, TR, TA, SP
Research and Training Center for
the Psychiatrically Disabled
Albert Einstein College of Medicine
1300 Morris Park Avenue
Bronx, NY 10461
(212) 824-6150

Contact: Director

UNIQUE FEATURE:
Researching the effects of deinstitutionalization on those who are disabled by LTMI.

ORGANIZATION:

This center is one of two research and training centers funded by the National Institute of Disability and Rehabilitation Research in conjunction with the National Institute of Mental Health, designated to develop and disseminate knowledge concerning rehabilitation of persons with LTMI. The mission of the Center is to conduct research and training activities crucial to the rehabilitation needs of persons with LTMI.

Presently, research areas include: VR outcome studies, development of standardized disability determinations, and rehabilitation interventions in the home, community, and criminal justice system. Vocational programs are provided through an affiliated network of agencies in the New York metropolitan area.

INFORMATION/MATERIALS AVAILABLE:

Training and technical assistance are offered upon request, on a case by case basis. An annual conference is conducted to disseminate latest developments in psychiatric rehabilitation and community support. Staff members are also available as speakers and presenters for Grand Rounds, conferences, and workshops.

Fountain House, Inc. SP, TA, TR, RM, RE
426 West 47th Street
New York, NY 10036
(212) 582-0340

Contact: Director of Education

UNIQUE FEATURE:

Developed, implemented and researched the clubhouse program model. Continuously conducting research and training on clubhouse management and the development of TE and SE.

ORGANIZATION:

Fountain House is a non-profit organization established in 1948 to develop comprehensive community-based rehabilitation programs for persons with psychiatric disabilities. Fountain House, the origin of the "clubhouse model," is operated jointly by members and paid staff. Services include a full range of residential, social and vocational programs. In the programs provided, members have assumed ever increasing levels of responsibility and leadership. The van Ameringen Center for Education and Research, established in 1985, develops and disseminates knowledge concerning the efficacy of clubhouse programs.

Received a three year grant from Robert Woods Johnson Foundation to conduct the National Clubhouse Expansion Program for the purpose of strengthening current clubhouses, developing new clubhouses, and increasing TE opportunities available in clubhouse programs.

Recently began an Independent Employment Project with funding from a MH agency. The project provides job support off the job site to members who have achieved competitive employment. Support is available during evenings and weekends.

INFORMATION/MATERIALS AVAILABLE:

Materials available include a number of articles and publications related to the clubhouse approach, as well as videotapes which illustrate aspects of program operation. A complete listing of resource materials is available upon request. Fountain House staff provide training and technical assistance related to the development and operation of a clubhouse model. The training is conducted at Fountain House. Technical assistance is available to programs which want to implement the clubhouse approach.

REGION III

National Association of Rehabilitation Facilities (NARF) — PR, IC, TA, RM

P. O. Box 17675
Washington, D.C. 20041
(703) 648-9300

Contact: Director, Community Employment Projects

UNIQUE FEATURE:

Resource for information on legislative issues related to rehabilitation and to the operation of rehabilitation facilities.

ORGANIZATION:

A major national trade association representing medical and VR concerns to the Federal government. Conducting three major national grants: a Projects with Industry grant subcontracting with 10 agencies; a National Supported Employment Demonstration Project to survey rehabilitation providers, locate exemplary model programs, and provide technical assistance; and an on-the-job training grant through the Department of Labor providing time-limited support to employees.

INFORMATION/MATERIALS AVAILABLE:

Technical assistance available on a wide range of topics such as staffing issues, comparison of the cost of one model of SE with other models, impediments to implementing SE, the effectiveness of combining models. Publishes a Supported Employment Resource Guide including a topical bibliography and resource list available to non-members for a nominal fee and weekly and monthly newsletters on rehabilitation issues. Will share information on the results of their National Survey of Supported Employment Providers and on the benefits versus the costs of SE.

National Institute on Disability and Rehabilitation Research (NIDRR)
Office of Special Education and Rehabilitation Services
U.S. Department of Education
400 Maryland Avenue S.W.
MS 2305
Washington, D.C. 20202
(202) 732-1134

FU, RE, IR

Contact: Director

UNIQUE FEATURE:

Federal agency supporting research program related to all disabilities.

ORGANIZATION:

Supports a comprehensive research program related to rehabilitation of individuals who are disabled by a wide range of conditions. Disseminates information about developments in rehabilitation procedures, methods and devices. Funds Rehabilitation Research and Training Centers, Rehabilitation Engineering Centers, as well as research and demonstration projects, field-initiated research projects, innovation grants, and fellowships. NIDRR currently funds two Research and Training Centers for psychiatric rehabilitation, two research and demonstration projects related to SE with persons with LTMI, and three field initiated projects relating to MH/VR collaboration, employer participation in SE for persons with LTMI, housing services and options for persons who are psychiatrically ill.

INFORMATION/MATERIALS AVAILABLE:

Information on current NIDRR projects and on grant application procedures. NIDRR also publishes Rehab Brief, a monthly digest that presents current research information relevant to rehabilitation practitioners.

Rehabilitation Services Administration (RSA)
Office of Special Education and Rehabilitative Services
U.S. Department of Education
Switzer Building
330 "C" Street, S.W.
Washington, D.C. 20202
(202) 732-1406 or 1347

FU, IR

Contact: Office of Program Operations, Office of Developmental Programs

UNIQUE FEATURE:

Federal agency providing funding for special projects related to VR and administering State VR programs.

ORGANIZATION:

The Federal partner in the State-Federal VR program that supports a variety of services to assist individuals with all types of disabilities to maximize their potential for employment and independent living. Especially relevant are the functions performed by the two offices cited above. The Office of Developmental Programs oversees the funding of special project grants, training grants, Projects with Industry (PWI) grants, and coordination of the Independent Living Program. The Office of Program Operations is responsible for overseeing the administration of the basic state VR formula grant programs including SE, the client assistance program, the Randolph/Sheppard Program, as well as programs in the areas of deafness and blindness. RSA currently funds 27 state change grants for SE, two PWI grants for persons with LTMI, and a number of service and training projects related to rehabilitation of persons who are psychiatrically disabled.

INFORMATION/MATERIALS AVAILABLE:

Information on current service projects, training projects, and programs related to SE and to enhancing services to persons with LTMI. Information on grant application procedures.

Brookes Publishing Co. RM
P. O. Box 10624
Baltimore, MD 21285
1-800-638-3775 (outside MD)
(301) 337-9580 (inside MD)

Contact: Order Department

UNIQUE FEATURE:

Publishes texts in the allied health and human service fields.

ORGANIZATION:

Publishes text books in the fields of developmental disabilities, special education, VR, physical and occupational therapy, speech/language/hearing, and other human services.

INFORMATION/MATERIALS AVAILABLE:

References on wide range of topics relevant to rehabilitation. Especially useful are texts on SE, development of non-sheltered employment options, job development, assessment of severe handicaps, and analysis and measurement of rehabilitation outcomes. Free catalog upon request.

Johns Hopkins University Press RM
701 West 40th Street
Suite 275
Baltimore, MD 21211
1-800-537-JHUP

Contact: Customer Services

UNIQUE FEATURE:
Publishes texts in the social sciences.

ORGANIZATION:
Publishes text and reference books on a wide range of topics. Relevant to rehabilitation are books listed under the topics of "Psychiatry and Psychology" and "Policy Studies in Employment and Welfare."

INFORMATION AVAILABLE:
Free catalog of books scheduled for publication in the coming six months. Free catalog of all JHUP books in print, grouped by topic area. Especially noteworthy are Work and Mental Illness and Vocational Rehabilitation of Persons with Prolonged Mental Illness.

The National Institute of RU, RE, RM
Mental Health (NIMH)
Division of Education and Service Systems Liaison
Community Support and Advocacy Branch
Parklawn Building, Room 11C-22
5600 Fishers Lane
Rockville, MD 20857
(301) 443-3653

Contact: Director, CSP

UNIQUE FEATURE:
Federal agency conducting research related to LTMI and responsible for administering the Community Support Program.

ORGANIZATION:
NIMH is the Federal agency responsible for supporting programs of research, research training, and resource development in the neurosciences, behavioral and psychobiological sciences; in epidemiodology, etiology, clinical course, treatment, and prevention of major mental disorders; and in-service delivery and rehabilitation for individuals with LTMI.

Within NIMH, the Community Support Program (CSP) works with States and communities to promote the development of community-based MH,

rehabilitation, and supportive services. CSP provides service demonstration grants to State MH authorities to develop promising community-based approaches for treating and rehabilitating individuals with serious mental disorders. CSP also supports the development of various technical assistance materials such as monographs, manuals, and state-of-the-art reports on community support services.

INFORMATION/MATERIALS AVAILABLE:

Resource materials and information on the demonstration grant program. Requests should specify the particular area(s) of interest, such as crisis response services, case management services, housing, model community support programs, evaluation, self-help, family support or others.

The Schapiro Training and Employment Program (S.T.E.P. Inc.)
701 St. Paul Street, Suite 402
Baltimore, MD 21202
(301) 625-1877

SP, RM

Contact: Executive Director

UNIQUE FEATURE:

Rehabilitation program that pioneered in the development of SE for persons with LTMI.

ORGANIZATION:

A non-profit organization serving people with chronic psychiatric disabilities through a comprehensive, community integrated VR program. Philosophically, STEP believes that successful VR will primarily occur through SE in integrated, "normal" work settings. The program will not direct people to prevocational or sheltered workshop settings. "Mainstreaming" placements throughout Baltimore and Maryland are obtained through a "partnership alliance" with employers aided by business contacts of STEP's Board of Directors.

Components of the program are the Intake Center, Supported Employment Program, Placement Program, and the Community Liaison Program. A rehabilitation counselor, supported by a placement technician, will support and teach individuals job interviewing and resume writing, will make on the job visits when warranted, and assist with financial considerations of employment versus disability income. Additionally, the placement technician will maintain a close, two year relationship with the employer and assist with placement in a second job setting if it becomes necessary.

INFORMATION/MATERIALS AVAILABLE:

Informational brochure, program design.

Matrix Research Institute
Kenilworth 106 / 2979 School House Lane
Philadelphia, PA 19144
(215) 438-8200

RE, TR, TA, RM

Contact: Executive Director

UNIQUE FEATURE:

Research and training focused on human service delivery systems.

ORGANIZATION:

A non-profit organization engaged in the design, support, and evaluation of human service delivery systems. Activities focus on programmatic development and policy issues related to creation of alternatives to institutionalization. Research and training, state and nationwide, is in the areas of program evaluation, human services planning and systems design, applied research and improvement of information systems.

Affiliation with the University of Pennsylvania provides resources, facilities, and organizational structure. Contractual and working relationship exists with the Pennsylvania Department of Public Welfare. Partnership activities focus on improving community-based residential, social and vocational programs for the LTMI. Other contractual projects include developing innovative approaches to transitional, affirmative, and supported rehabilitation programs for persons with LTMI and persons who are mentally retarded.

Recent projects focus on SE, VR, training and technical assistance on community support services, and training personnel for working with people with LTMI.

INFORMATION/MATERIALS AVAILABLE:

Project Descriptions. Specific information given by request.

National Mental Health
Consumers Association (NMHCA)
311 South Juniper Street, Suite 902
Philadelphia, PA 19107
(215) 735-6367

CO, IC, RM, TA, TR

Contact: Executive Director

UNIQUE FEATURE:

Promotes empowerment of consumers and development of consumer-run alternatives to treatment.

ORGANIZATION:

NMHCA is a membership organization of past and present recipients of MH services. Among stated purposes of the agency are:

- To protect the rights of MH consumers
- To further the development of local user controlled alternatives linked by a national clearinghouse
- To improve the quality of life for MH consumers by ending discrimination in housing and employment, addressing the needs of people who are homeless and economically deprived and advocating for increased public benefits
- To provide information and technical assistance concerning the rights of users of MH services and the development of self-help and consumer operated programs. These activities include focusing on employment needs and issues as well as the operation of vocational programs with a self-help philosophy.

INFORMATION/MATERIALS AVAILABLE:

Names of those MH consumers who can provide consultation, technical assistance and training on the development and implementation of consumer run programs are available upon request. A newsletter is available to members and supporting members. A series of technical assistance pamphlets on topics related to empowering users of MH services will be available in the near future.

Pennsylvania Office of Vocational Rehabilitation — IA, SP
Department of Labor and Industry
1300 Labor & Industry Building
7th and Forster Streets
Harrisburg, PA 17120
(717) 787-5735 or 4885

Contact: Manager of Facilities & Grants
Management Section
Mental Health Specialist

UNIQUE FEATURE:

Interagency collaboration in eastern urban and rural settings using single stream funding to implement SE.

ORGANIZATION:

The Pennsylvania State VR agency began its interagency collaborative experience in 1983 when it joined with the Pennsylvania Office of Mental Health to develop a joint RFP process for establishing industry-integrated rehabilitation programs. Over a three-year period, 25 projects

were jointly funded. This experience provided the basis for the formation of the Pennsylvania Supported Employment Task Force in 1985. Through the Task Force, eight state agencies contributed 1.2 million dollars toward single stream funding of SE. The Pennsylvania State VR agency acts as fiscal agent and coordinator of the SE Task Force.

INFORMATION/MATERIALS AVAILABLE:

Can answer questions about this State's experience with joint funding, the problems encountered, and the results of their collaborative efforts with the State MH agency. Can provide information about their role and functions in the Pennsylvania SE Task Force.

Western Psychiatric Institute and Clinic
Department of Neuropsychological Assessment and Rehabilitation Services
University of Pittsburgh
3811 O'Hara Street
Pittsburgh, PA 15213
(412) 624-2866

SP, RE, TR, TA, RM

Contact: Program Director or Clinical Coordinator of Rehabilitation Services

UNIQUE FEATURE:

A neuropsychological assessment service operating out of a psychiatric rehabilitation-oriented program.

ORGANIZATION:

Western Psychiatric Institute and Clinic houses the Department of the University of Pittsburgh School of Medicine and is the psychiatric specialty hospital and community MH center of the University Health Center of Pittsburgh. Nationally recognized, WPIC is one of the largest University based clinical, educational, and research facilities in the United States. Specialized assessment and comprehensive rehabilitation services are offered to MH clients through the Department of Neuropsychological Assessment and Rehabilitation Services (NARS).

Assessment services offered include intellectual evaluation, academic achievement testing, personality and psychopathology measurement, and neuropsychological assessment of brain and information processing dysfunction. Emphasis is placed upon the clinical utility of assessment data in psychiatric rehabilitation planning and process. In addition, comprehensive VR services are offered including vocational assessment and counseling, referral and liaison with the state VR system and local providers and educational facilities. Also offered are individualized job readiness and job seeking skills training, work adjustment and job retention counseling, and long-term supportive services.

WPIC conducts regional and national training programs in interagency collaboration and psychiatric rehabilitation for both direct line staff and staff development personnel. Graduate and post doctoral level training programs are offered in rehabilitation counseling, psychological and neuropsychological and assessment and in rehabilitation research in head injury, learning disability, and LTMI.

INFORMATION/MATERIALS AVAILABLE:

Various print and video resource and instructional materials in LTMI, psychiatric rehabilitation and related areas are available through the NARS Department. Specific examples include a videotape detailing the development and implementation of a SE program for MH clients in a rural southwestern Pennsylvania community and an instructional material package for training programs in psychiatric rehabilitation and interagency collaboration. The latter consists of a four volume resource manual, an instructor's manual of didactic lectures, and a case study manual of supporting slides, exercises, case study materials and videotapes.

International Association of
Psychosocial Rehabilitation Services
(IAPSRS)
P. O. Box 278
McLean, VA 22101
(703) 237-9385

PO, RM, TA

Contact: Executive Director

UNIQUE FEATURE:

Professional organization for those working in the field of psychosocial rehabilitation.

ORGANIZATION:

A professional organization serving agencies and staff working in the field of psychosocial rehabilitation. Members include community-based rehabilitation centers and agencies, as well as rehabilitation components of mental hospitals, community MH centers, and other service organizations. Advocates for persons with LTMI on policy and legislation issues and disseminates information about psychosocial rehabilitation through publications and conferences.

INFORMATION/MATERIALS AVAILABLE:

Maintains a directory of psychosocial rehabilitation facilities and a directory of State Chapters of IAPSRS. Currently updating a national directory of community facilities providing services to persons with LTMI. Members receive the IAPSRS Newsletter, the Psychosocial Rehabilitation Journal, Community Support Network News, and Legislative Network. Technical assistance available to member agencies.

National Alliance for the Mentally Ill (NAMI) — CO, RM

1901 North Fort Myer Drive, Suite 500
Arlington, VA 22209-1604
(703) 524-7600

Contact: Member

UNIQUE FEATURE:

One of the fastest growing advocacy organizations.

ORGANIZATION:

A nationwide self-help consumer organization generally composed of people with LTMI and their relatives and friends. Collective efforts of the 800 affiliated groups include educating the public about LTMI, eradication of stigma, funding research into causes and cures, promoting the best quality of life possible for people with schizophrenia, depressive disorders, and other disabling brain diseases.

Support at local levels involves sharing information and experiences. Networking done at state and national levels. State and national conventions held. Membership addresses state and local governments for more effective services for people with LTMI. Research on LTMI supported through the NAMI Research Fund.

In association with the Public Citizen Health Research Group, NAMI rated each of the states on hospitals, outpatient services, rehabilitation and housing for persons with LTMI. Ratings are published in Care of the Seriously Mentally Ill: A Rating of State Programs.

INFORMATION/MATERIALS AVAILABLE:

Organizational outline of purpose and activity areas, newsletters, resource list of educational materials in a variety of media formats (books, brochures, films, papers), membership lists by state, Speakers' Bureau listing. Information on special committees available to membership.

National Mental Health Association (NMHA) — CO, TA, IR, RM

1021 Prince Street
Alexandria, Virginia 22314-2971
(703) 684-7722

Contact: Public Policy Department

UNIQUE FEATURE:

Resource for advocacy materials and legislative information related to LTMI.

ORGANIZATION:

An advocacy and public education organization that works for legislation affecting the rights and treatment of persons with LTMI and for improved community-based treatment facilities. Carries on public awareness campaigns to effect changes in the attitudes of neighborhoods and businesses toward those with LTMI. State and local associations serve as information and referral sources for direct services within their local areas.

INFORMATION/MATERIAL AVAILABLE:

Information on state or local associations, the names of key MH personnel in state government, State MH service programs, and availability of state funding for MH related services. A resource for information on federal legislation that affects MH and on the effect of rehabilitation upon persons with LTMI. Free catalogs listing films, educational and advocacy materials are available. Publications over a variety of topics such as depression, schizophrenia, and psychotherapeutic medications. A recent publication, Operation Help, is specifically designed to explain MH coverage under Medicaid and assist advocates with improving their own state's Medicaid plan. A monthly newsletter, Focus, informs members of news in the MH field.

National Rehabilitation Association (NRA) PO, RM, TR
633 South Washington Street
Alexandria, VA 22314
(703) 836-0850

Contact: Executive Director

UNIQUE FEATURE:

Professional organization for those working in the field of rehabilitation.

ORGANIZATION:

An organization for rehabilitation professionals and others interested in the advocacy of persons with disabilities and the advancement of rehabilitation services. Of the seven divisions offering members opportunities for professional growth, four are of special interest. The Job Placement Division provides training in a variety of placement practices including those related to Transitional and Supported Employment. The National Rehabilitation Counseling Association advances the counseling relationship as a basic component in rehabilitation services. The Vocational Evaluation and Work Adjustment Association provides training and certification programs for vocational evaluators, work adjustment specialists, and job coaches from a variety of settings including SE, MH, and corrections. The National Rehabilitation Association supports the professional development of administrators and supervisors of evaluators, counselors, placement specialists, and other rehabilitation professionals.

INFORMATION/MATERIALS AVAILABLE:

Information on the organization, its divisions, training programs, and publications. Publications available for purchase include Medications Frequently Used to Treat Persons with Mental Illness and the most recent Switzer monograph, The Rehabilitation of Persons with Long Term Mental Illness in the 1990's. Members receive the Journal of Rehabilitation and the NRA Newsletter. The divisions, state, and regional chapters also publish journals and/or newsletters.

The Social Center for Psychiatric Rehabilitation — SP, TA

2810 Dorr Avenue
Fairfax, VA 22031
(703) 698-1655

Contact: Executive Director

UNIQUE FEATURE:

A 25-year-old clubhouse program that utilizes the psychosocial rehabilitation approach of skill teaching.

ORGANIZATION:

A non-profit contract corporate agency which services referrals of those with LTMI to its treatment and rehabilitation program. Participants enter the program after or instead of inpatient care. Individualized treatment plans are based on the client's rehabilitation goals, assessment of the level of functioning, and specific skills needed to meet the particular goal. Daily program activities focus on social interaction, vocational skills, and independent living skills. Weekend and evening recreation and socializing program are available.

Interventions focus on providing a supportive low-stress environment, teaching community living and vocational skills, and developing community support for the client. The Center emphasizes vocational planning. Clients may be involved in extended sheltered employment, work adjustment training, TE or SE in either group or individual placements.

INFORMATION/MATERIALS AVAILABLE:

Informational brochure, newsletter, program summary. Technical assistance to rehabilitation professionals.

Job Accommodation Network (JAN) IC
West Virginia University
809 Allen Hall
Morgantown, WV 26506-6122

Contact: 1-800-526-7234 (outside WV)
1-800-526-4698 (inside WV)

UNIQUE FEATURE:

Brokers information about job accommodation for all disabilities.

ORGANIZATION:

Maintains a data base containing specific information on job accommodations made by employers for employees and applicants who are disabled. Focuses on how the individual work environment can be adapted to match a worker's abilities and functional limitations. Via its toll-free number, JAN shares information about accommodations used successfully by other employers in similar situations. May refer individuals with disabilities to appropriate support groups, MH agencies, or other service agencies. Approximately 6-12% of their requests each quarter are related to cognitive disabilities, including LTMI.

INFORMATION/MATERIALS AVAILABLE:

Will share information about methods of accommodation used in similar cases. Accommodations for persons with LTMI included restructuring work assignments, work hours, and social factors as well as educating fellow workers about behavior that may indicate a need for follow-up. Publishes a quarterly bulletin, Solution Briefs, that shares general principles learned from situations related to a specific topic. Services are free.

REGION IV

Fellowship House SP, TA, TR, RM
5711 South Dixie Highway
South Miami, FL 33143
(305) 667-1036

Contact: Executive Director

UNIQUE FEATURE:

A psychosocial program that promotes heavy involvement of its members and staff in local civic activities and organizations.

ORGANIZATION:

A non-profit psychosocial rehabilitation center which facilitates the transition of adult former mental patients back into the community. The Social Program enables clients to improve social skills, and/or learn new ones, through supported activities and relationships. A continuum of

residential programs includes choices from highly supervised to on-call supported housing. Running of Fellowship House is the core of the Vocational Program. General, rather than specific, work skills are taught. Bridging the gap to competitive employment are TE and SE.

Based on the philosophy that the center and its members should contribute back to the community from which it receives support, center staff and members in all programs are active in local community groups. For example, the fund raising efforts of Center members and staff accounted for one third of the total funds raised by the local Kiwanis Club during a fund raising drive. In another example of community involvement, center members videotape meetings of the South Miami Commission and edit the tapes for airing on local cable television. Recently these center members were hired by the city to begin live broadcasting of the Commission meetings on local cable network.

INFORMATION/MATERIALS AVAILABLE:

Brochures in English and Spanish, the agency newsletter, publication related to TE and SE. Experiental training and technical assistance are available. The Center has developed an internship program teaching management of psychosocial rehabilitation facilities to master's level students from allied health disciplines such as nursing, social work, and VR. A curriculum guide for this internship program is being developed and will be available in early 1990. An eight-tape video training series produced by the Center on Psychosocial Rehabilitation is also available.

Community Friendship, Incorporated SP
85 Renaissance Parkway, N.E.
Atlanta, GA 30308
(404) 875-0381

Contact: Executive Director

UNIQUE FEATURE:

A comprehensive rehabilitation program that has developed a close and effective working relationship with both VR and MH.

ORGANIZATION:

A non-profit psychiatric rehabilitation center that facilitates personal, social and vocational adjustment of adults who have been treated in the MH system. Members experience the privileges and responsibilities of belonging to a community, learn and practice work habits and skills that promote independence and employment, and participate in educational and social programs to increase competencies. The Day Program is composed of various work units to meet prevocational, work adjustment, and employment needs, promoting development of life skills, vocational competence, and a sense of belonging to a community. The Work Opportunities Program provides work adjustment skills more advanced than the Day Program to those who have not been able to succeed at competitive levels

of employment. With staff support, members are taught to choose, get, and keep a job in the competitive market. A variety of social and recreational experiences are offered by the Social Club. Goals are to have a good time and develop appropriate social skills. Case Management provides services to those without an advocate who have limited ability to obtain social and health services. A semi-supervised apartment complex is maintained to promote independent living skills.

The local VR agency assigns a vocational counselor to the center. The center suggests to the VR counselor when MH clients are ready for VR services. The counselor then authorizes the center to provide a VR evaluation and any necessary work adjustment training. This close relationship fosters the efficient entry of MH clients into the VR system.

INFORMATION/MATERIALS AVAILABLE:

Organizational brochure, program brochures, including TEP brochure.

REGION V

AMI of Rock Island and Mercer Counties — SP, RM
Vocational Development Program
P. O. Box 4238
Rock Island, IL 61204-4238
(309) 788-6413

Contact: Associate Director, Vocational Development

UNIQUE FEATURE:

An AMI organization that has developed innovative and award-winning residential and employment programs.

ORGANIZATION:

The Alliance for the Mentally Ill of Rock Island and Mercer Counties has developed a continuum of residential and employment services for persons with LTMI. Well integrated into the local community, AMI has developed working agreements with state, local, and private organizations. Cited by Dr. E. Fuller Tory as a program that works. Developed a community education program in 1987 that was awarded the Kremitz Award by the National Alliance for the Mentally Ill for combating stigma associated with LTMI.

A leader in establishing affirmative enterprises. Established an upscale restaurant in downtown Rock Island in 1983. Mes Amis Restaurant is now completely managed by clients, providing transitional and permanent employment, and has expanded into catering, lunch deliveries to local businesses, and a food cart at community events. AMI has also developed and implemented a successful SE program using primarily individual placements within local businesses.

INFORMATION/MATERIALS AVAILABLE:

Can provide anti-stigma and family educational materials. Can also assist in the development of marketing plans for affirmative enterprises and SE programs.

Thresholds
2700 N. Lakeview Avenue
Chicago, IL 60614
(312) 281-3800

SP, RE, TR, TA, RM

Contact: Director, Training Institute

UNIQUE FEATURE:

Innovative programs combined with flexible models of service delivery.

ORGANIZATION:

Thresholds is a CARF accredited comprehensive rehabilitation agency for the LTMI which emphasizes five major rehabilitation goals: vocational adjustment, educational achievement, prevention of rehospitalization, social skill development and independent living. To accomplish these goals, Thresholds provides a full range of rehabilitation and support services tailored to individual client need, with many possible entry-exit points. Special outreach and residential services are provided for persons with LTMI and deafness along with complete access to Threshold's clubhouse and rehabilitation programs. A clubhouse and rehabilitation system geared specifically for adolescents who are emotionally distrubed include a licensed and accredited high school, along with literacy training, GED and college preparation. A Robert Woods Johnson grant provides mobile job support staff without caseloads who are free to routinely visit all job sites for purposes of crisis prevention or intervention. The community scholar program provides special tutoring and mobile educational support staff for persons with LTMI enrolled in college. A special program for women with LTMI and pre-school children assists the mother in promoting the development of her child. Projects for the prevention of homelessness include outreach to those living on the streets, development of resources to meet their needs, and assuring that state hospital residents have necessary living resources prior to discharge.

Thresholds also operates a Training Institute which provides in vivo and didactic learning experiences for professionals from any public or private agency who wants and needs to gain knowledge and skills related to psychiatric rehabilitation.

INFORMATION/MATERIALS AVAILABLE:

An annotated bibliography of research conducted at Thresholds, brochures that describe the agency's programs, and other publications are available at no charge. Newsletters, including a SE newsletter, are available on subscription basis. Training services, including speakers

who travel, individually designed training and technical assistance are available upon request. The basic cost for training is $200 per person/ per day. Training fees are negotiable.

Rise, Incorporated
8406 Sunset Road
Spring Lake Park, MN 55432
(612) 786-8334

SP, TR, TA, RM

Contact: Executive Director

UNIQUE FEATURE:

Provides a wide range of rehabilitation programs for a variety of disabilities through the development of partnerships with industry.

ORGANIZATION:

A non-profit agency established for the purpose of planning, developing, and operating cost-effective and comprehensive rehabilitation programs. Serves persons with physical, mental, emotional, and/or learning disabilities, enabling them to become as independent and self-sufficient as possible.

A continuum of VR services meet the individual needs of anyone of working age (16 to 65) through real work experiences. Vocational Evaluation establishes realistic and suitable employment goals. Work Activity Training offers structured work assistance and specialized training services. Work Activity Employment is for those who have basic work competencies but productively fall below sheltered workshop standards. Sheltered Employment offers structured work and support. TE prepares people for competitive employment in specific areas. Supported Employment Services in Mental Health Units provide vocational training, psychosocial counseling and job placement for people with psychiatrical disabilities. Community Based Training and Employment offers work opportunities for the developmentally disabled. Workers' Compensation Services meets the employment needs of those disabled in industrial or non-industrial accidents, while Independent Living Skills enables people with mental disabilities to live within the community. School Work Transition for Students with Special Needs assists high school seniors in developing employment goals and vocational service plans. Job Placement Services uses placement specialists to assist in supported or competitive positions in the community.

INFORMATION/MATERIALS AVAILABLE:

Training and technical assistance brochures, newsletters, vocational publications, video presentation on individuals who progressed into SE in the business community. Making It Work is a manual that focuses on SE for persons with LTMI.

Program for Assertive Community Treatment (PACT)
Mendota Mental Health Institute
108 South Webster
Madison, WI 53703
(608) 266-0721

SP, TR, TA, RE

Contact: Program Director

UNIQUE FEATURE:

Developed, implemented, and researched the training in community living (TCL) program model. Conducting controlled studies on this model since 1970.

ORGANIZATION:

PACT is the outpatient program of the Mendota Mental Health Institute. Using a multidisciplinary team composed of clinical and rehabilitation staff, PACT provides continuous case management and comprehensive services to adults with psychiatric disabilities. The team has longitudinal responsibility for the provision of all major outpatient rehabilitation services, including crisis intervention. Team staff, many of whom are at the master's level, contribute a range of skills to provide community-based support and instruction. Members of the team skilled in VR perform job development, job support, job coaching, and skill teaching functions. Team staff are available 24 hours a day.

While the program is self-contained, services are not center-based. The vast majority of services are performed in community settings where the client lives, works, and socializes. Two-thirds of staff time is spent in planned community-based service delivery and unplanned crisis intervention.

INFORMATION/MATERIALS AVAILABLE:

PACT offers training on a wide range of topics on effective program and systems operations related to the provision of community-based services. Training in VR practice and how it relates to the rehabilitation of persons with LTMI is provided on-site at a cost of $259 per person per day. Other training is available by individual negotiation.

REGION VI

Arkansas Research and Training Center
in Vocational Rehabilitation
P. O. Box 1358
Hot Springs, AR 71902
(501) 624-4411 Ext. 292

RE, TR, TA, RM

Contact: Publications Department

UNIQUE FEATURE:

Research and training on enhancing the employability of persons with disabilities.

ORGANIZATION:

Conducted research and training activities within the priority area of "Enhancing Employability of Persons with Disabilities." Focused on improving the individual client's skills in locating, applying and interviewing for jobs, in maintaining effective interpersonal relationships, and in stress management. Additional efforts focused on the work environment itself, promoting more effective relationships with employers and developing environmental support systems.

INFORMATION/MATERIALS AVAILABLE:

A variety of client assessment instruments including the Employability Maturity Interview and the Job Skills Assessment. Multimedia behavioral training packages such as Getting Employment Through Interview Training and Rational Behavior Problem Solving. Training materials for developing a peer counseling system and a companion training program to assist in the organization of such programs. A catalog of these and other related materials available on request. Training programs, presentations, and technical assistance on using the Center's products is available for a nominal fee.

Oklahoma Department of Mental Health — IA, SP, IR
P. O. Box 53277
Capitol Station
Oklahoma City, OK 731-52-3277
(405) 271-7474

Contact: Commissioner

UNIQUE FEATURE:

Developing a collaborative service delivery system between MH and VR.

ORGANIZATION:

This state MH agency is operating an RSA funded project to develop and implement a statewide comprehensive community-based program for rehabilitation assessment, vocational preparation, and job development/placement for persons with LTMI. The major objectives of this project are:

1. to develop program guidelines
2. to develop and implement comprehensive, community based rehabilitation assessment, vocational preparation, training, counseling and support programs
3. to develop and implement job development/placement programs as a component of community MH care

4. to develop and implement cooperative and collaborative interagency agreements with VR, Employment Security Commission, Vocational Education and other relevant agencies
5. to develop and conduct an information and education program for providers and for the public
6. to establish a statewide service system by 1992

INFORMATION/MATERIALS AVAILABLE:

The following materials are available at no cost:

1. program standards and criteria
2. program guidelines, policies and procedures
3. copies of model cooperative agreements with VR, the State Employment Services, Social Security Administration, Job Training Partnership Act and Vocational Education
4. SE agreement between VR and the Department of MH
5. educational and publicity information including brochures and sample broad-cast public service announcements
6. information on program cost, administration and staff training

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Jackson Street Fairweather Program SP
5518 Jackson Street
Houston, TX 77004
(713) 524-6106

Contact: Intake Coordinator

UNIQUE FEATURE:

A jointly funded Fairweather Lodge program model targeted toward homeless individuals with LTMI.

ORGANIZATION:

Funded through a joint effort of Harris County Mental Health/Mental Retardation Authority (MHMRA) and the Housing and Urban Development Agency. Administered by U.S. Harris County MHMRA, the Jackson Street Program provides a community-based residential training facility with transitional housing, psychosocial rehabilitation, and vocational training. This program is designed to meet the needs of an individual who does not have access to traditional or permanent housing, but who is capable of learning to live independently within a lodge society within a reasonable amount of time.

Receives referrals of eligible homeless LTMI individuals from state hospitals, MHMRA outpatient clinics, local shelters, food pantries, and social service agencies. The facility on Jackson Street houses a maximum of 10 residential trainees in vocational training and psychosocial rehabilitation. Basic janitorial skills and work behaviors are the focus of vocational training while psychosocial rehabilitation encourages trainees to develop self-help, independent living skills. After living,

training, and working together for approximately six months, residential trainees move into the community as members of a new, self-supporting lodge group. In addition to residential training, the Jackson Street Program continues to make available to nonresidential trainees the benefits of vocational training and psychosocial rehabilitation. The program operates a member-owned small business, Cleaner's Co-Operative, incorporated in 1984.

INFORMATION/MATERIALS AVAILABLE:

Program description and brochure.

Phoenix House, Inc. SP
722 1/2 Tension Memorial
Dallas, TX 75223
(214) 321-7036

Contact: Executive Director

UNIQUE FEATURE:

Fairweather Lodge Program model.

ORGANIZATION:

Phoenix House, Inc. is a five-year-old private non-profit agency that assists people with LTMI in meeting their housing and vocational needs. Services are delivered through its administering of a Fairweather Lodge Program.

Clients with repeated or long term psychiatric hospitalization who have a poor work history and minimal or no family support are selected from hospitals and the community as members.

Phoenix helps locate and rent a house, assists them to furnish and fix up their home, helps to locate and negotiate group employment contracts, and assists them to find transportation. Staff is provided by Phoenix to each lodge and provides support to members with outpatient care and medication compliance. The coordinator performs personal-social adjustment and on-the-job training.

INFORMATION/MATERIALS AVAILABLE:

Phoenix currently operates nine lodges in the Dallas area, serving 70 persons. Can provide information on program philosophy, description and goals.

REGION VII

Independence Center — SP, TR, TA
Psychiatric Rehabilitation Facilities
4380 West Pine Boulevard
St. Louis, MO 63108
(314) 533-6511

Contact: Assistant Director

UNIQUE FEATURE:

One of four clubhouses in the U.S. authorized to provide training in the clubhouse model. The only clubhouse that has a contractual relationship with a hospital making it eligible for third party reimbursement.

ORGANIZATION:

The second largest clubhouse in the world, Independence Center is a non-profit service organization established by parents and friends of persons with LTMI. Based on the Fountain House model, the Center is composed of two clubhouses, each with a system of personal and community support services that focus on enhancing employment, independent living, and social opportunities.

The overall purpose is to promote successful community adjustment, employment, and support. The four major suppositions that provide the strength and direction for the theoretical base are 1) the potential for productivity, 2) the generative and regenerative power of work, 3) the need for social interaction, and 4) the obligation to help members to live in the community with dignity.

The Center is designated by Fountain House as a provider of training and technical assistance regarding the clubhouse model of psychiatric rehabilitation. The goal is to prepare members, staff, and administrators to implement or improve and expand a clubhouse model program. The training includes both programmatic and fund raising information.

INFORMATION/MATERIALS AVAILABLE:

On-site training is provided on a tuition basis at Independence Center. Accommodations in the Center's guest house are included in the tuition. Consultation and technical assistance are also available to community groups considering the establishment of a clubhouse program.

REGION VIII

Colorado Division of Rehabilitation — IA, SP
Department of Social Services
1575 Sherman Street, 4th Floor
Denver, CO 80203-1714
(303) 866-2866

Contact: Program Administrator for SE

UNIQUE FEATURE:

Interagency collaboration in a western rural setting using contributions of time and talent to implement SE.

ORGANIZATION:

This State VR agency developed several interagency collaborative efforts around SE, especially in rural areas. Multiagency consortiums become the focal point for private agencies and new employers to access public service agencies. Member agencies contribute time, talent, and information. Information sharing and networking are key to the success of these efforts, with members sharing information on job leads and marketing the services of the resource pool to employers. Service delivery and client job sharing often occur across disabilities. In one instance, the local MH agency provides SE services for clients who are mentally retarded or brain injured.

INFORMATION/MATERIALS AVAILABLE:

Can answer questions about this State's experience in organizing resource pools, providing centralized job development, resolving problems with this type of project, non-monetary contributions of various members and other strategies for maximizing use of resources spread over a large geographic area.

Consumer Case Manager (CCM) Program — SP
Regional Assessment and Training Center, Inc. (RATC)
3520 West Oxford Avenue
Denver, CO 80236
(303) 762-4335

Contact: Executive Director, RATC

UNIQUE FEATURE:

A nationally known pilot project that selects, trains and employs primary consumers of MH services to act as case managers for their peers.

ORGANIZATION:

Created as part of a three-year plan to improve services to persons with LTMI, the program is based on the concept that primary consumers

represent a previously untapped source of knowledge and expertise which would serve as a valuable resource for improving MH care in Colorado.

The plan was developed by the Colorado Division of Mental Health (DMH) and funded by the Colorado General Assembly. Its creation was a joint effort of DMH and the Regional Assessment and Training Center (RATC), a private, non-profit, psychosocial rehabilitation agency based in Denver. The program has been supported through staff and/or funding from DMH, Colorado Rehabilitation Services, the Denver Mental Health Centers Consortium, the Community College of Denver, the Colorado Community College and Occupational Education System, the Denver Employment and Training Administration and the Governor's Job Training Office.

A six-month training curriculum with college credit was developed from a job task analysis performed in committed job sites. Training included seven weeks classroom training and four months on-job-training with direct skill training support.

Of the 18 persons who completed the training, 15 have been continuously employed as consumer case managers since April, 1987 (one additional graduate was hired into another position in the MH system). In most cases, CCMs act as assistants to MH case managers and other providers. They are actively involved in guiding clients through the entitlement benefit acquisition process, providing transportation, teaching activities of daily living skills, offering assistance in obtaining housing and providing outreach, monitoring and follow-up services.

Consumer Case Managers have expressed the hope that their work can help to reduce the stigma of LTMI by demonstrating to MH providers, the general public and other consumers that with the right kind of support and opportunity, persons who have experienced a LTMI can become contributing members of their community. Based on this success, expansion of the CCM program into other areas of Colorado has been initiated and new roles and functions for consumer service providers are currently being developed.

INFORMATION/MATERIALS AVAILABLE:

The executive director can provide information about the project including assessment and training design, collaborative financing and support structures. Printed materials about the project are available.

Rocky Mountain Resource
and Training Institute (RMRTI)
3805 Marshall Street, Suite 202
Wheat Ridge, CO 80033
(303) 420-2942

RM, TA, TR, RE

Contact: Assistant Director

UNIQUE FEATURE:

Training Agency focusing on implementation of SE and development of one-year certificate program for job coaches.

ORGANIZATION:

RMRTI is a private, non-profit training and technical assistance agency whose purpose is to promote full integration within the community for people with disabilities through technical assistance, marketing, education and research. Training is designed and scheduled annually and is based on an analysis of an annual needs survey. A current training focus includes strategies for implementing and operating effective SE programs. Technical assistance is designed and tailored to meet specific agency needs. Services are available primarily to agencies in Colorado and, on a limited basis, to other agencies in RSA federal region VIII. There is no cost to Colorado participants. Out-of-state participants pay a fee of $35 per day.

INFORMATION/MATERIALS AVAILABLE:

In addition to training and technical assistance, RMRTI produces and disseminates a quarterly newsletter. In conjunction with the Northern Colorado Regional Rehabilitation Continuing Education Program, RMRTI is also developing a one-year certificate program to train Employment Training Specialists.

National Alliance of Mental Patients (NAMP) — CO, IC, RM

P. O. Box 618
Sioux Falls, SD 57101
Telephone: not available

Contact: By mail only

UNIQUE FEATURE:

Advocacy organization focusing on consumer-run alternatives to treatment.

ORGANIZATION:

A national advocacy organization "of and for the mentally ill." Diverse membership is composed of those currently in the MH system, those out of the system for years, friends and supporters. Focuses include: major rights protection, advocacy issues, legislative decision-makers, government officials, the media, the public and other members. Work is toward the end to all forms of forced or coerced psychiatric treatment and development of humane, voluntary alternatives including self-help and other non-medical programs. The fundamental mission is dedicated to empowering people labelled mentally disabled to learn to independently exercise their legal rights.

Also serves as a clearinghouse for trained member consultants in many areas related to ex-patient issues including homelessness, patient-run alternatives, self-help and mutual support groups, ethical issues in psychiatric treatment. Involves constituencies in policy-making board and teleconferencing.

INFORMATION/MATERIALS AVAILABLE:

Information Packet available by providing a self-addressed, stamped envelope. Packet includes: goals and philosophy statement, bibliographies, and membership application. Quarterly newsletter also available. Will provide referral to local groups and agencies for information and/or advocacy issues.

REGION IX

Portals — SP, TR
301 S. Kingsley Drive
Second Floor
Los Angeles, CA 90020
(213) 387-1129

Contact: Associate Director

UNIQUE FEATURE:

Psychosocial rehabilitation program with an entrepreneurial component.

ORGANIZATION:

Portals is a multi-service, non-profit psychosocial rehabilitation agency which provides residential, socialization and vocational programs to members who have psychiatric disabilities. All Portals members are guaranteed paid employment, presently or in the future. The length of time a person must wait to be employed depends upon motivation, vocational maturity and job availability. Unpaid work opportunities include work crews in the work units of the clubhouse and volunteer positions in the community. Paid work opportunities include group employment in a local retail industry, employment in the Corporate Cookie, an agency owned business, as well as part-time to full-time SE in local businesses with job coaching and off-site support. Job placement and follow along services are also available to help members become competitively employed.

Portals recently received an RSA training grant to develop a manual and a training program for MH and VR practitioners and administrators for the purpose of developing pre-vocational components within county day treatment programs and private MH organizations.

INFORMATION/MATERIALS AVAILABLE:

Program brochures are available upon request, as are individual issues of the newsletter, thru Portals. Training and technical assistance is available to owners of board and care homes in the Los Angeles area.

REGION X

The Employment Network Project — IC, TA, TR
University of Oregon
135 College of Education
Eugene, OR 97403
(503) 686-5311

Contact: Project Director

UNIQUE FEATURE:

Major information and technical assistance broker for information and data related to SE.

ORGANIZATION:

Co-funded by two national organizations, the Project provides technical assistance and training to states engaged in systems change to SE. It developed a national network of consultants for SE and a consortium of nationally known training groups to provide regional training institutes. A portion of these institutes will focus on SE for special populations, including persons with LTMI. Brokers have access to emerging information from around the country and coordinates with other technical assistance and training resources.

INFORMATION/MATERIALS AVAILABLE:

Emerging "best-practice" information and materials, referral to consultants and innovative projects, as well as training institutes focused on specific content areas. Technical assistance provided on a cost-share basis. An extensive bibliography on SE materials is available on request.

Laurel Hill Center — SP, RM
2621 Augusta Street
Eugene, OR 97403-2295
(503) 485-6340

Contact: Executive Director

UNIQUE FEATURE:

CARF accredited VR and training facility for those who are psychiatrically disabled.

ORGANIZATION:

A non-profit agency serving individuals with psychiatric disabilities through a variety of programs. A supportive environment aids in regaining self-confidence and feelings of self-worth. Basis for programs is the belief that those served can make choices and take on responsibilities which lead to productive lives.

Four types of activities comprise the focus of the program: performing daily living activities, working for wages in the community, developing relationships with other people, and finding satisfying ways to spend leisure time. Each program offers a wide range of options and opportunities.

Specific programs include the Social/Harmony House to assist with development and practice of social skills necessary to establish a supportive network of friends. Finding low-cost housing and learning independent living skills is provided through the Independent Living Program. SWEEP (Supervised Work Experience and Employment Program) assists participants in becoming self-supporting in the job market. Five work areas which are subcontracted with local businesses include: food service, electronics assembly, work processing, custodial, and retail sales. Senior Outreach assists in developing a supportive network of friends, transportation to planned activities, and accessing available social services.

INFORMATION/MATERIALS AVAILABLE:

Training manual, Medication Management slide-tape presentation, speakers on various aspects of psychiatric/vocational rehabilitation, newsletters, brochures, training and technical assistance.

Oregon State University
Teaching Research Division
345 N. Monmouth Avenue
Monmouth, OR 97361
(503) 838-1220 Ext. 391

SP, TR, RE, RM

Contact: Director, SED Program

UNIQUE FEATURE:

Provides vocational training and the development of social and practical living skills for youth who are considered to be the most severely emotionally disturbed in the state of Oregon.

ORGANIZATION:

Teaching Research, a division of the Oregon State System of Higher Education has established an extensive program for youth who are severely emotionally disturbed. The program consists of a small group home, an apartment complex, an intensive foster care program, a resource room in a public school, a vocational component of four phases of job training.

Initially students are placed in volunteer jobs until they demonstrate that they can manage a work situation, after which they are placed in paid employment. The three phases of paid employment provide for gradually increasing independence at the work site along with a decrease of job coaching.

Concurrently with vocational training, clients learn social and interpersonal skills, use of the telephone, budgeting money, and other skills basic to independent living. The assessment and development of these skills forms a major thrust of the program.

INSTRUCTION/MATERIALS AVAILABLE:

On-site training in the vocational and residential models is available for $300 per week plus room and board. Also available is the Teaching Research Curriculum for assessing and teaching the skills important for severely emotionally disturbed youth to acquire. The Taxonomy and Assessment is useful in developing an IWRP. Teaching modules for a variety of life skills are available or in the process of being developed.

Community Psychiatric Clinic SP
Stepworks Vocational Program
4319 Stone Way North
Seattle, WA 98103
(206) 461-3642

Contact: Executive Director, Community Psychiatric
Clinic Program Manager, Stepworks

UNIQUE FEATURE:

A non-profit community MH center that is CARF accredited and a VR vendor.

ORGANIZATION:

Community Psychiatric Clinic (CPC) is a non-profit community MH center providing a wide range of MH services primarily to adults. with chronic and serious LTMI. Stepworks is the vocational program at CPC and provides services to more than 100 clients per year. Stepworks operates janitor and landscape maintenance crews which are used for assessment and skill building, and employs approximately 20 clients. Stepworks also places clients into volunteer positions ranging from 4 to 30 hours per week. These positions are used for either assessment and skill training to prepare a client for job placement, or they are used as long-term placements for clients that are not able or interested in seeking competitive employment. The Stepworks program has a large SE component that has placed over 40 clients into paid employment this past year. These positions range from 10 to 40 hours per week and the type of support provided includes both job coaching to teach job related skills and case management to monitor the clients mental status while adjusting

to work. The program is CARF certified and a DVR vendor. It is funded primarily through a vocational contract with King County, fee for service with DVR, and fee for services provided by the janitoral and landscape crews.

INFORMATIION/MATERIALS AVAILABLE:

Can provide information on the techniques and methods of VR for those with LTMI, especially in the areas of SE and the use of work crews. Will share information on how this MH agency achieved CARF accreditation.

Kitsap Initiatives SP
Empire Employment
2819 First Avenue, Suite 250
Seattle, WA 98121
(206) 448-4204

Contact: Executive Director, Kitsap Initiatives
Program Manager, Empire Employment

UNIQUE FEATURE:

Experimenting with teaching MH case managers how to perform job coach functions.

ORGANIZATION:

Kitsap Initiatives fosters and facilitates independence and self-esteem in individuals with disabilities through job placement and community integration. One of its four satellites, Empire Employment receives referrals from MH through VR to provide SE for persons with LTMI. It receives a negotiated fee from VR for assessment and job development services regardless of the time spent completing these tasks. Work skill building or training is provided on a fee-for-service basis. Empire Employment provides vocational services for an extended period, usually one year. At that time, Empire Employment teaches MH case managers how to perform the job coaching and follow along functions that Empire Employment performed during the services period. This training is provided on-site with the goal of transferring the client's dependence and trust from the Empire Employment coach to the MH case manager. Thus when VR closes the case, MH provides a variety of long-term support services, including job coaching or job follow along.

INFORMATION/MATERIALS AVAILABLE:

Can provide information on this agency's experiences with structuring SE for clients with LTMI, targeting jobs and employers for this disability group, training MH case managers as job coaches, and coordinating services with both MH and VR.

Job Training Partnership Act (JTPA) FU

Contact: Governor's Training and Employment Office or
Local Training and Employment Office for
referral to State agency that manages JTPA

UNIQUE FEATURE:
Funding resource used by MH, VR, and private agencies.

ORGANIZATION:
A block grant program administered at the State and local level that offers training and other employment assistance to both disadvantaged and displaced workers through partnership with local Private Industry Councils (PIC's) and State Job Training Coordinating Councils (SJTCC's). Serves economically disadvantaged adults and youth, dislocated workers, Native Americans, and veterans. Up to 10% of persons receiving services, if not economically disadvantaged, must have special barriers to employment such as limited English, prison record, substance abuse, age, or a physical or mental handicap in order to be eligible for services.

INFORMATION/MATERIALS AVAILABLE:
Contact local JTPA's for information on eligibility of individuals for training and eligibility of organizations for training projects.

National Directory of Fairweather Programs
Department of Psychology
125 West Fee Hall
Michigan State University
East Lansing, MI 48824
(517) 355-0166

Contact: Director

UNIQUE FEATURE:
Information gathered from Small Group Training Programs and Community Lodge Program administrators.

ORGANIZATION:
This directory is an update of the 1986 Director of Community Lodges and Small Group Training Programs. The bulk of the information contained in the directory was collected during September 1988. A survey served as a basis for the directory and other information and updates were obtained via telephone inquires.

Contents include program name, lodge name, coordinator, address, phone, year program established, characteristics, housing, types of employment,

number of members, income and entitlements, funding sources and other pertinent information.

Independence House
1014 N. Zang
Dallas, TX 75208
(214) 941-6054

Contact: Coordinator, CSP and/or Residential Supervisor

UNIQUE FEATURE:

Joint involvement of agencies, variety of training and work environments available.

ORGANIZATION:

Independence house is a "club house" model providing social, vocational and residential components. Residents are provided vocational evaluation, counseling, training, support services and job placement.

The residential components offers an apartment living program which currently provides seven (7) transitional, and twenty (20) long-term apartments serving 105 persons. Residents are accepted from the hospital and from the community.

Included in the transitional apartments are three (3) apartments structured as a "cluster." These are located in the same complex and provide an on-site staff member for twenty-four hour crisis intervention. The remaining apartments function with autonomy.

Independence House (staffed by Dallas County Mental Health/Mental Retardation employees) will assign one full time residential coordinator to work with apartment residents, who will be available to provide active advocacy: in acquiring necessary community resources; solving daily problems in living; and in maintaining the necessary stability to keep the individual in the community.

The length of stay in the Transitional Apartment Program will usually be no more than eight (8) months after which time the individual will be expected to go on to more independent living arrangements while still remaining active in the non-residential aspects of the community support program. However, if the individual is assessed as in need of continuing residential support, he may move into the permanent (long-term) apartments.

INFORMATION/MATERIALS AVAILABLE:

Can provide program description and publishes a newsletter. IH apartment program has been in existence for more than five (5) years. Cooperative effort of Dallas County Mental Health/Mental Retardation and the Texas Rehabilitation Commission.

APPENDIX H

Prime Study Group

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APPENDIX I

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Hot Springs, AR 71902

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